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2d Session
HOUSE OF REPRESENTATIVES
REPORT
100-661

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

MAY 31, 1988.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 2470]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Catastrophic Coverage Act of 1988".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; references in Act; table of contents.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

Sec. 101. Expanding scope of benefits under part A.
Sec. 102. Deductibles and coinsurance under part A.
Sec. 103. Part A premium for medicare buy-ins.

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Sec. 104. Effective dates, transition, and conforming amendments.

Subtitle B—Supplemental Medicare Premium

Sec. 111. Imposition of supplemental medicare premium.
Sec. 112. Establishment of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.
Sec. 113. Study of tax incentives for purchase of coverage for long-term care.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

Sec. 201. Limitation on medicare part B cost-sharing.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. Coverage of home intravenous drug therapy services.
Sec. 204. Coverage of screening mammography.
Sec. 205. In-home care for certain chronically dependent individuals.
Sec. 206. Extending home health services.
Sec. 207. Research on long-term care for medicare beneficiaries.
Sec. 208. Study of adult day care services.

Subtitle B—Medicare Part B Premium and Financing

Sec. 211. Adjustments in medicare part B premium.
Sec. 212. Establishment of Federal Catastrophic Drug Insurance Trust Fund; fund transfers.
Sec. 213. Creation of Medicare Catastrophic Coverage Account.

Subtitle C—Miscellaneous Provisions

Sec. 221. Changes in certification of medicare supplemental health insurance policies.
Sec. 222. Adjustment of contracts with prepaid health plans.
Sec. 223. Mailing of notice of medicare benefits and information describing participating physician program.
Sec. 224. Changes in civil money penalties for certain practices of health maintenance organizations and competitive medical plans.

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

Sec. 301. Requiring medicaid buy-in of premiums and cost-sharing for indigent medicare beneficiaries.
Sec. 302. Coverage and payment for pregnant women and infants with incomes below poverty line.
Sec. 303. Protection of income and resources of couple for maintenance of community spouse.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

Sec. 401. Establishment.
Sec. 402. Duties.
Sec. 403. Membership.
Sec. 404. Staff and consultants.
Sec. 405. Powers.
Sec. 406. Report.
Sec. 407. Termination.
Sec. 408. Authorization of appropriations.

Subtitle B—OBRA Technical Corrections

Sec. 411. Technical corrections to certain health care provisions in the Omnibus Budget Reconciliation Act of 1987.

Subtitle C—Miscellaneous Provisions

Sec. 421. Maintenance of efforts.
Sec. 422. Rate reduction for medicare eligible Federal employees.

Sec. 423. Study and reports by the Office of Personnel Management on offering medicare supplemental plans to Federal medicare eligible individuals, and other changes.
Sec. 424. Benefits counseling and assistance demonstration project for certain medicare and medicaid beneficiaries.
Sec. 425. Case management demonstration projects.
Sec. 426. Extensions of expiring provisions.
Sec. 427. Medicare home health care denial of benefits advisory committee.
Sec. 428. Prohibition of misuse of symbols, emblems, or names in reference to Social Security or Medicare.
Sec. 429. Demonstration projects with respect to chronic ventilator-dependent units in hospitals.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

SEC. 101. EXPANDING SCOPE OF BENEFITS UNDER PART A.

Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a), by striking paragraphs (1) through (4) and inserting the following:

"(1) inpatient hospital services;

"(2) extended care services for up to 150 days during any calendar year;

"(3) home health services; and

"(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (d)(1).";

(2) by amending subsection (b) to read as follows:

"(b) Payment under this part for services furnished to an individual may not be made for—

"(1) extended care services furnished to the individual during a calendar year after such services have been furnished to the individual for 150 days during that year, or

"(2) inpatient psychiatric hospital services furnished to the individual after such services have been furnished to the individual for a total of 190 days during his lifetime.";

(3) by amending subsection (c) to read as follows:

"(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

"(2) The period described in this paragraph—

"(A) begins on the first day of medicare entitlement, and

"(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

"(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

"(4) In this subsection:

"(A) The term 'first day of medicare entitlement' means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

"(B) The term 'inpatient mental health services' means—

"(i) inpatient psychiatric hospital services, and

"(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.";

(4) in subsection (d)—

(A) in paragraph (1), by striking "and one subsequent period of 30 days" and inserting ", a subsequent period of 30 days, and a subsequent extension period", and

(B) in paragraph (2)(B), by inserting "or a subsequent extension period" after "30-day period";

(5) in subsection (e), by striking "post-hospital", and

(6) by striking subsections (f) and (g).

SEC. 102. DEDUCTIBLES AND COINSURANCE UNDER PART A.

Section 1813 (42 U.S.C. 1395e) is amended—

(1) by amending paragraphs (1) through (3) of subsection (a) to read as follows:

"(1)(A) Subject to subparagraph (C), the amount payable for inpatient hospital services furnished to an individual during the individual's first period of hospitalization to begin during a calendar year shall be reduced by a deduction equal to the inpatient hospital deductible for that year or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed.

"(B) For purposes of subparagraph (A), the term 'period of hospitalization' means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ending on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

"(C) In the case of an individual with respect to whom—

"(i) a period of hospitalization begins during December of any calendar year,

"(ii) an inpatient hospital deductible is imposed with respect to such period of hospitalization, and

"(iii) a period of hospitalization begins during January of the following calendar year,

no inpatient hospital deductible shall be imposed with respect to a period of hospitalization beginning in January of such following year (but such period of hospitalization shall not be taken into account in determining the application of an inpatient hospital de-

ductible for any period of hospitalization beginning for such individual after January 31 of such following year).

"(D) If the Secretary terminates a contract under section 1876 during a year, no inpatient hospital deductible shall be imposed during the remainder of the year in the case of an individual who can demonstrate to the satisfaction of the Secretary that, during a period of enrollment with the organization in the year, the individual was admitted to a hospital for inpatient hospital services for which the organization was obligated to make payment under such section.

"(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

"(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

"(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 9th day) on which he is furnished such services during the year.

"(B) Before September 1 of each year (beginning with 1988), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

"(C) The Secretary shall, in September of each year (beginning with 1988) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents)."; and

(2) by striking paragraph (3) of subsection (b).

SEC. 103. PART A PREMIUM FOR MEDICARE BUY-INS.

Subsection (d) of section 1818 (42 U.S.C. 1395i(2)) is amended to read as follows:

"(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

"(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).".

SEC. 104. EFFECTIVE DATES, TRANSITION, AND CONFORMING AMENDMENTS.

(a) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this subtitle shall take effect on January 1, 1989, and shall apply—

(A) to the inpatient hospital deductible for 1989 and succeeding years,

(B) to care and services furnished on or after January 1, 1989,

(C) to premiums for January 1989 and succeeding months, and

(D) to blood or blood cells furnished on or after January 1, 1989.

(2) ELIMINATION OF POST-HOSPITAL REQUIREMENT FOR EXTENDED CARE SERVICES.—The amendments made by this subtitle, insofar as they eliminate the requirement (under section 1812(a)(2) of the Social Security Act) that extended care services are only covered under title XVIII of such Act if they are post-hospital extended care services, shall only apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989.

(b) HOLD HARMLESS PROVISIONS.—In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act, as in effect on December 31, 1988) began before January 1, 1989, and had not yet ended as of such date—

(1) the amendment made to section 1813(a)(1) of such Act shall not apply to services furnished during that spell of illness during 1989 or 1990, and

(2) the amount of any deductible under section 1813(a)(2) of such Act (as amended by this subtitle) shall be reduced during that spell of illness during 1989 or 1990 to the extent the deductible under such section was applied during the spell of illness.

(c) ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act, outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendment made by section 101).

(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act for cost reporting periods beginning on or after October 1, 1988, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendment made by section 101).

(d) MISCELLANEOUS CONFORMING AMENDMENTS.—

(1) Section 1811 (42 U.S.C. 1395c) is amended by striking "hospital, related post-hospital" and inserting "inpatient hospital services, extended care services".

(2) Section 1814 (42 U.S.C. 1395f) is amended—

(A) in paragraphs (2)(B) and (6) of subsection (a), by striking "post-hospital" each place it appears;

(B) in subsection (a)(2)(B), by striking ", for any of the conditions" and all that follows up to the semicolon;

(C) in subsection (a)(7)(A)—

(i) by striking "and" at the end of clause (i),

(ii) by striking the semicolon at the end of clause (ii) and inserting ", and", and

(iii) by adding at the end the following new clause:

"(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;"; and

(D) in subsection (d)(3)—

(i) by striking "60 percent" and "80 percent" and inserting "100 percent" both places, and

(ii) by striking "two-thirds of".

(3) Section 1832(b) (42 U.S.C. 1395k(b)) is amended by striking " 'spell of illness'," and the comma before "and".

(4) Section 1861 (42 U.S.C. 1395x) is amended—

(A) by striking subsection (a);

(B) in subsection (e)—

(i) in the matter before paragraph (1), by striking "paragraph (7) of this subsection, and subsection (i) of

this section" and inserting "and paragraph (7) of this subsection",

(ii) in the third sentence, by striking "section 1814(f)(2), and subsection (i) of this section" and inserting "and section 1814(f)(2)",

(iii) in the fifth sentence, by striking ", except for purposes of subsection (a)(2),", and

(iv) by striking the second sentence;

(C) by striking subsection (i);

(D) in subsections (v)(1)(G)(i), (v)(2)(A), and (v)(3), by striking "post-hospital" each place it appears; and

(E) in subsection (y)—

(i) by striking "Post-Hospital" in the heading and by striking "post-hospital" each place it appears;

(ii) in paragraph (1), by striking "(except for purposes of subsection (a)(2))", and

(iii) in paragraphs (2) and (3), by striking "spell of illness" and "spell" each place either appears and inserting "year",

(iv) in paragraph (2)(A)(i), by striking "30 days" and inserting "45 days",

(v) in paragraph (3), by striking "one-eighth" and all that follows through "31st day" and inserting "the coinsurance amount established under section 1813(a)(3)(C) for each day before the 46th day", and

(vi) by striking paragraph (4).

(5) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended by striking "post-hospital" each place it appears.

(6) Subsections (d)(1) and (f) of section 1883 (42 U.S.C. 1395tt) are amended by striking "post-hospital" each place it appears.

Subtitle B—Supplemental Medicare Premium

SEC. 111. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

"PART VIII—SUPPLEMENTAL MEDICARE PREMIUM.

"Sec. 59B. Supplemental medicare premium.

"SEC. 59B. SUPPLEMENTAL MEDICARE PREMIUM.

"(a) IMPOSITION OF PREMIUM.—In the case of an individual to whom this section applies, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a supplemental premium equal to the annual premium for such year determined under subsection (c).

"(b) INDIVIDUALS SUBJECT TO PREMIUM.—This section shall apply to an individual for any taxable year if—

"(1) such individual is a medicare-eligible individual for more than 6 full months beginning in the taxable year, and

"(2) such individual's adjusted income tax liability for the taxable year equals or exceeds $150.

"(c) Determination of Amount of Supplemental Premium.—For purposes of this section—

"(1) In general.—Except as otherwise provided in this subsection, the annual premium determined under this subsection with respect to any individual for any taxable year shall be equal to the product of—

"(A) the supplemental premium rate determined under subsection (d) or (e) (whichever applies) for the taxable year, multiplied by

"(B) the amount determined by dividing—

"(i) the individual's adjusted income tax liability for the taxable year, by

"(ii) $150.

"(2) Limitation on annual premium.—

"(A) Years before 1994.—In the case of any taxable year beginning before 1994, the annual premium determined under this subsection with respect to any individual shall not exceed the limitation determined under the following table:

"In the case of taxable years beginning in:	*The limitation is:*
1989	*$800*
1990	*850*
1991	*900*
1992	*950*
1993	*1,050.*

"(B) Years after 1993.—In the case of any taxable year beginning in a calendar year after 1993, the annual premium determined under this subsection with respect to any individual shall not exceed—

"(i) the limitation which would be in effect under this paragraph for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the percentage (if any) by which—

"(I) the medicare-part B value for the 2nd preceding calendar year, exceeds

"(II) such value for the 3rd preceding calendar year.

If the limitation determined under the preceding sentence is not a multiple of $50, such limitation shall be rounded to the nearest multiple of $50.

"(C) Medicare-part B value.—

"(i) In general.—For purposes of subparagraph (B), the term 'medicare-part B value' means, with respect to any calendar year, an amount equal to the excess of—

"(I) the average per capita part B outlays for the year, over

"(II) 12 times the monthly premium for months in such calendar year established under section 1839 of such Act (without regard to subsections (b), (f), (g)(4), and (g)(5) thereof).

"(ii) AVERAGE PER CAPITA PART B OUTLAYS.—For purposes of clause (i), the term 'average per capita part B outlays' means, with respect to a calendar year—

"(I) the outlays under part B of title XVIII of the Social Security Act for the year, divided by

"(II) the average number of individuals covered under such part during the year.

"(iii) SPECIAL RULE FOR COVERED OUTPATIENT DRUGS.—In applying the limitation under subparagraph (B) with respect to taxable years beginning in any calendar year before 1998, for purposes of this subparagraph—

"(I) the term 'outlays' does not include outlays for covered outpatient drugs (as defined in section 1861(t)(2) of the Social Security Act), and

"(II) the monthly premium shall be computed under clause (i)(II) excluding premiums under section 1839(g) of such Act attributable to the prescription drug monthly premium.

"(3) TABLES.—The annual premium shall be determined under tables which shall be prescribed by the Secretary. Such tables shall be based on the foregoing provisions of this subsection; except that such tables may have adjusted income tax liability brackets of less than $150.

"(d) DETERMINATION OF SUPPLEMENTAL PREMIUM RATE FOR YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the supplemental premium rate determined under this subsection shall be the sum of the catastrophic coverage premium rate and the prescription drug premium rate determined under the following table:

"In the case of any taxable year beginning in:	*The catastrophic coverage premium rate is:*	*The prescription drug premium rate is:*
1989	*$22.50*	*0*
1990	*27.14*	*$10.36*
1991	*30.17*	*8.83*
1992	*30.55*	*9.95*
1993	*29.55*	*12.45.*

"(e) SUPPLEMENTAL PREMIUM RATE FOR YEARS AFTER 1993.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, except as provided in paragraph (2), the supplemental premium rate determined under this subsection shall be the sum of—

"(A) the catastrophic coverage premium rate (which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage determined under paragraph (3) for the calendar year in which the taxable year begins, and

"(B) the prescription drug premium rate (which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage

determined under paragraph (4) for the calendar year in which the taxable year begins.

"(2) SUPPLEMENTAL PREMIUM RATE CANNOT GO DOWN, AND CANNOT GO UP BY MORE THAN $1.50.—

"(A) IN GENERAL.—In no event shall the supplemental premium rate determined under this subsection for any taxable year beginning in a calendar year after 1993—

"(i) be less than, or

"(ii) exceed by more than $1.50,

the supplemental premium rate in effect under this section for taxable years beginning in the preceding calendar year.

"(B) DETERMINATION OF COMPONENT RATES WHERE SUBPARAGRAPH (A) APPLIES.—If subparagraph (A) affects the supplemental premium rate determined under this subsection for taxable years beginning in any calendar year, the supplemental premium rate determined after the application of subparagraph (A) shall be allocated between the catastrophic coverage premium rate and the prescription drug premium rate on the basis of the respective amounts of such rates without regard to the application of subparagraph (A).

"(3) PERCENTAGE ADJUSTMENT FOR CATASTROPHIC COVERAGE PREMIUM RATE.—

"(A) IN GENERAL.—The percentage determined under this paragraph for any calendar year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(B) OUTLAY-PREMIUM PERCENTAGE.—

"(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the outlay-premium percentage for any calendar year is—

"(I) the percentage by which the per capita catastrophic outlays in the 2nd preceding calendar year exceed such outlays in the 3rd preceding calendar year, reduced (including below zero) by

"(II) the percentage by which the per capita catastrophic coverage premium liability for the 2nd preceding calendar year exceeds such liability for the 3rd preceding calendar year (determined as if the catastrophic coverage premium rate for the 2nd preceding calendar year were the same as the rate in effect for the 3rd preceding calendar year).

If there is no excess described in subclause (I) or (II), such subclause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) ADJUSTMENT FOR MORE RECENT INCREASES IN COST-OF-LIVING.—If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for the calendar year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(C) RESERVE ACCOUNT PERCENTAGE.—

"(i) IN GENERAL.—The reserve account percentage for any calendar year is the percentage which the rate change determined under clause (ii) is of the catastrophic coverage premium rate which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year. If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) DETERMINATION OF RATE CHANGE.—The rate change determined under this clause for any calendar year is the adjustment in the catastrophic coverage premium rate (otherwise in effect for taxable years beginning in the 2nd preceding calendar year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this section for such taxable years equal to 63 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) DETERMINATION OF SHORTFALL OR EXCESS.—The shortfall (or excess) determined under this clause for any calendar year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this subsection or by reason of section 1839(g)(2) of the Social Security Act but not credited to the Account).

"(D) DEFINITIONS.—For purposes of this paragraph—

"(i) PER CAPITA CATASTROPHIC OUTLAYS.—The term 'per capita catastrophic outlays' means, with respect to any calendar year, the amount (as determined by the Secretary of Health and Human Services) equal to—

"(I) the outlays during such year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, divided by

"(II) the average number of individuals entitled to receive benefits under part A of title XVIII of the Social Security Act during such calendar year.

"(ii) PER CAPITA CATASTROPHIC COVERAGE PREMIUM LIABILITY.—The term 'per capita catastrophic coverage premium liability' means, with respect to any calendar year, the amount (as determined by the Secretary) equal to—

"(I) the aggregate premiums imposed by this section for taxable years beginning in such calendar year to the extent attributable to the catastrophic coverage premium rate, divided by

"(II) the number of individuals who had premium liability under this section for such taxable years.

"(iii) PERCENTAGE INCREASE IN CPI.—The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5)) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(4) PERCENTAGE ADJUSTMENT FOR PRESCRIPTION DRUG PREMIUM RATE.—The percentage determined under this paragraph for any calendar year shall be determined under rules similar to the rules of paragraph (3); except that—

"(A) in determining the prescription drug premium rate for any calendar year before 1998, the following percentages shall be substituted for 20 percent in paragraph (3)(C)(iii)(I):

"In the case of calendar year:	*The percentage is:*
1994	*75*
1995	*50*
1996	*25*
1997	*25;*

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998,

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund, and

"(D) any reference to the catastrophic coverage premium rate shall be treated as a reference to the prescription drug premium rate.

"(f) DEFINITIONS AND SPECIAL RULES.—

"(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'medicare-eligible individual' means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

"(B) EXCEPTIONS.—The term 'medicare-eligible individual' shall not include for any month—

"(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for

such month solely by reason of the payment of a premium under section 1818 of such Act, or

"(ii) any qualified nonresident.

"(2) Special rules for joint returns.—In the case of a joint return—

"(A) Where premium applies to both spouses.—If both spouses meet the requirements of subsection (b)(1) for the taxable year—

"(i) such spouses shall be treated as 1 individual for purposes of applying this section, except that

"(ii) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply.

"(B) Where premium applies to only 1 spouse.—If only 1 spouse meets the requirements of subsection (b)(1) for the taxable year—

"(i) this section shall be applied separately with respect to such spouse, and

"(ii) the adjusted income tax liability of such spouse shall be determined under paragraph (4)—

"(I) by taking into account one-half of the income tax liability determined with respect to the joint return, and

"(II) by taking into account under clause (ii) of paragraph (4)(C) only amounts attributable to such spouse.

"(3) Separate returns by married individuals.—If an individual is married as of the close of the taxable year (within the meaning of section 7703) but does not file a joint return for the taxable year and such individual does not live apart from his spouse at all times during the taxable year—

"(A) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply if both the individual and the spouse of the individual meet the requirements of subsection (b)(1) with respect to the calendar year in which the taxable year begins (determined without regard to subparagraph (B) of this paragraph),

"(B) if such individual does not otherwise meet the requirements of subsection (b)(1), such individual shall be treated as meeting the requirements of subsection (b)(1) for the taxable year if the spouse of such individual meets such requirements with respect to the calendar year in which the taxable year begins, and

"(C) in applying subparagraph (C) of paragraph (4)—

"(i) the dollar limitation of clause (i) thereof shall be 1/2 of the amount which applies to a joint return where both spouses meet the requirements of subsection (b)(1), and

"(ii) the individual shall be deemed to receive social security benefits during the taxable year in an amount not less than 1/2 of the aggregate social security benefits received by such individual and his spouse during the taxable year.

"(4) Adjusted income tax liability.—For purposes of this section—

"(A) In general.—The term 'adjusted income tax liability' means an amount equal to the income tax liability, reduced by the excess (if any) of—

"(i) 15 percent of the governmental retiree exclusion amount (if any) determined under subparagraph (C) for the taxable year, over

"(ii) the amount of the credit allowable under section 22 for the taxable year.

"(B) Income tax liability.—The term 'income tax liability' means—

"(i) the tax imposed by this chapter (determined without regard to this section), reduced by

"(ii) the credits allowed under part IV of this subchapter (other than under sections 31, 33, and 34).

"(C) Governmental retiree exclusion amount.—The governmental retiree exclusion amount for any taxable year is the lesser of—

"(i) $6,000 ($9,000 in the case of a joint return where both spouses meet the requirements of subsection (b)(1) for the taxable year), or

"(ii) the amount which is received as an annuity (whether for a period certain or during 1 or more lives) under a governmental plan (as defined in the 1st sentence of section 414(d)) and which is includible in gross income under section 72 for the taxable year.

The amount determined under the preceding sentence shall be reduced by the social security benefits (as defined in section 86(d)) received during the taxable year.

"(D) Indexing.—In the case of any taxable year beginning in a calendar year after 1989, subparagraph (C)(i) shall be applied by substituting for each dollar amount contained in such subparagraph an amount equal to—

"(i) the dollar amount which would be in effect under subparagraph (C)(i) for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the cost-of-living adjustment determined under section 215(i) of the Social Security Act for the calendar year in which the taxable year begins.

Any amount determined under the preceding sentence shall be rounded to the nearest multiple of $50.

"(5) Qualified nonresident.—

"(A) In general.—For purposes of paragraph (1), the term 'qualified nonresident' means, with respect to any month during the taxable year, any individual if—

"(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is made under part A of title XVIII of the Social Security Act,

"(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

"(iii) such individual is present in a foreign country or countries for at least 330 full days during—

"(I) the 12-month period ending at the close of the taxable year, and

"(II) each of the 4 consecutive preceding 12-month periods.

"(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

"(6) COORDINATION WITH OTHER PROVISIONS.—

"(A) NOT TREATED AS MEDICAL EXPENSE.—For purposes of section 213, the supplemental premium imposed by this section for any taxable year shall not be treated as an expense paid for medical care.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax imposed by section 55.

"(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the supplemental premium imposed by this section shall be treated as if it were a tax imposed by section 1.

"(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the supplemental premium imposed by this section.

"(7) SECTION NOT TO AFFECT LIABILITY TO POSSESSIONS, ETC.—This section shall not apply for purposes of determining liability to any possession of the United States. For purposes of sections 932 and 7654, the supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter.

"(8) SHORT TAXABLE YEARS.—In the case of a taxable year of less than 12 months, this section shall be applied under regulations prescribed by the Secretary."

(b) INFORMATION REPORTING.—

(1) Subsection (a) of section 6050F of such Code is amended by striking "and" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) whether any individual meets the requirements of section 59B(b)(1) with respect to the calendar year (determined without regard to section 59B(f)(1)(B)(ii)), and".

(2) Section 6050F(b) of such Code is amended—

(A) by inserting "or making the determination under subsection (a)(2)" after "payments" in paragraph (1), and

(B) by inserting "and the information required under subsection (a)(2)," after "reductions," in paragraph (2).

(3) Section 6050F(c)(1)(A) of such Code is amended by inserting "and the information required under subsection (a)(2)" after "section 86(d)(1)(A)".

(c) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Part VIII. Supplemental medicare premium."

(d) ANNOUNCEMENT OF SUPPLEMENTAL PREMIUM RATE.—In the case of calendar year 1993 or any calendar year thereafter—

(1) not later than July 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the estimated supplemental premium rate under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the following calendar year, and

(2) not later than October 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the actual supplemental premium rate under such section for such taxable years.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

(2) WAIVER OF ESTIMATED TAX REQUIREMENT FOR YEARS BEGINNING IN 1989.—In the case of a taxable year beginning in 1989, the premium imposed by section 59B of the Internal Revenue Code of 1986 (as added by this section) shall not be treated as a tax for purposes of applying section 6654 of such Code.

SEC. 112. ESTABLISHMENT OF FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

(a) IN GENERAL.—Part A of title XVIII is amended by inserting after section 1817 the following new section:

"FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND

"SEC. 1817A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Catastrophic Coverage Reserve Fund' (in this section referred to as the 'Reserve Fund'). The Reserve Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Reserve Fund, from the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 attributable to the supplemental catastrophic premium rate, amounts equivalent to 100 percent of the amount of outlays made under this part attributable to the amendments made by the Medicare Catstrophic Coverage Act of 1988. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Reserve Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury and on the basis of outlays, specified in the previous sentence, made; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess

of or were less than the appropriate amounts specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums (described in this paragraph) paid or deposited into the Treasury in the year.

"(3) With respect to monies transferred to this Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

"(b) The provisions of subsections (b) through (e) of section 1817 shall apply to the Reserve Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Reserve Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund.

"(c) In this part, with respect to the Reserve Fund, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) INTEREST ADJUSTMENT.—In July 1990, the Secretary of the Treasury shall calculate the interest lost to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to the lag between the outlays (attributable to the amendments made by this Act) from the Federal Hospital Insurance Trust Fund during 1989 and the transfers made to such Reserve Fund to cover such outlays. Appropriations under section 1817A(a)(2) of the Social Security Act (as inserted by subsection (a)) shall include the amount calculated under the previous sentence.

SEC. 113. STUDY OF TAX INCENTIVES FOR PURCHASE OF COVERAGE FOR LONG-TERM CARE.

(a) IN GENERAL.—The Secretary of the Treasury (in this section referred to as the "Secretary") shall conduct a study of Federal tax policies to promote the private financing of long-term care (as defined in subsection (d)). The study shall identify alternative methods of creating incentives, through the tax system, to encourage individuals to purchase insurance coverage for long-term care. The study shall also consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection.

(b) CONSULTATION.—The Secretary shall conduct the study required by subsection (a) in consultation with representatives of the insurance industry, providers of long-term care, and consumers.

(c) REPORT.—The Secretary shall report the results of the study required by subsection (a) to the Congress not later than November 30, 1988, together with the Secretary's recommendations for any changes in Federal law that the Secretary determines to be appropriate to promote the private financing of long-term care.

(d) LONG-TERM CARE DEFINED.—For purposes of this section, the term "long-term care" includes care and services provided by nursing homes, home health agencies, and other mechanisms for the delivery of long-term care services.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

SEC. 201. LIMITATION ON MEDICARE PART B COST-SHARING.

(a) In General.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) in subsection (c)—

(A) by striking "subsections (a) and (b)" and inserting "subsection (a) through (c)",

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B),

(C) by striking "this subsection" and inserting "this paragraph", and

(D) by striking "(c)" and inserting "(d)(1)";

(2) by redesignating subsection (d) as paragraph (2);

(3) in subsection (g), by striking "(a) and (b)" inserting "(a) through (c)"; and

(4) by inserting after subsection (b) the following new subsection:

"(c)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (2)) in a calendar year (beginning with 1990) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A) and in subsections (b)(2) and (b)(3) of section 1881, except as such provisions may apply to in-home care.

"(2) In this subsection, the term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under this part, the amounts of expenses that the individual incurs that are attributable to—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A) and in subsections (b)(2) and (b)(3) of section 1881.

"(3)(A) The part B catastrophic limit for 1990 is $1370. The part B catastrophic limit for any succeeding year shall be such an amount *(rounded to the nearest multiple of $1) as the Secretary estimates will result, in that succeeding year, in 7 percent of the average number of individuals enrolled under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in subsection (a)(1)(A)) during the year becoming entitled to benefits under this subsection.*

"(B) Not later than September 1 of each year (beginning with 1990), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

"(4) In the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876, in applying paragraph (1), the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(5)(A) Except as provided in subparagraph (B), expenses incurred by a medicare beneficiary for out-of-pocket part B cost-sharing shall be counted (consistent with subparagraph (C)) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876. In this paragraph, with respect to a medicare beneficiary enrolled in such a plan, the term 'out-of-pocket part B cost-sharing' includes deductibles and coinsurance under the plan for items and services covered under this part.

"(B) In the case of a medicare beneficiary enrolled in a month in a buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for items and services reimbursed under the plan shall not be treated as out-of-pocket part B cost-sharing for purposes of paragraph (1), but

"(ii) the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for out-of-pocket part B cost-sharing in an amount equal to the actuarial value (with respect to a month in the year involved) of the deductible and coinsurance amounts under part B (as computed by the Secretary for purposes of section 1876(e)(1), other than with respect to covered outpatient drugs) applicable on the average to individuals in the United States.

"(C) The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization, with respect to a plan that is not a buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that—

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred in each year under the plan for out-of-pocket part B cost-sharing (as defined in subparagraph (A)); and

"(ii) the organization will not undertake to charge a beneficiary during a year for services for which payment may be made under this part (other than for covered outpatient drugs) after the individual has incurred (whether through the organization or otherwise) out-of-pocket part B cost sharing in the year in an

amount equal to the part B catastrophic limit established under paragraph (1) for the year.

"(D) In this paragraph, the term 'buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the actuarial value of the coinsurance and deductibles under the plan with respect to benefits (other than covered outpatient drugs) under this title (as determined by the Secretary), is less than 50 percent of—

"(ii) the actuarial value of the coinsurance and deductibles for such benefits for all medicare beneficiaries (as determined by the Secretary) applicable on the average to individuals in the United States.

"(E) In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(c) (relating to catastrophic benefits).".

(c) NOTICE FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) will provide each individual, who is determined to have incurred (or has had paid on the individual's behalf) sufficient out-of-pocket part B cost sharing in a calendar year to qualify for payment for additional incurred expenses to be made pursuant to section 1833(c), with a notice that states that the individual has reached the part B catastrophic limit on out-of-pocket cost sharing for the year;".

(d) CONFORMING AMENDMENT.—The second sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking "1833(c)" and inserting "1833(d)(1)".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) DESCRIPTION OF COVERED OUTPATIENT DRUGS.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subparagraph (J) of subsection (s)(2) to read as follows:

"(J) covered outpatient drugs (as defined in subsection (t)); and", and

(2) in subsection (t)—

(A) by inserting "and paragraph (2)" after "subsection (m)(5)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraph:

"(2) Subject to paragraph (3), the term 'covered outpatient drug' means—

"(A) a drug which may be dispensed only upon prescription and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling;

"(B) a biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(ii) is produced at an establishment licensed under such section to produce such product; and

"(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3)(A) The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as, as part of, or as incident to, any of the following (and for which payment may be included under this title):

"(i) Inpatient hospital services (described in subsection (b)(2)).

"(ii) Extended care services (described in subsection (h)(5)).

"(iii) Physicians' services under subparagraph (A) or (B) of subsection (s)(2).

"(iv) Dialysis supplies under subsection (s)(2)(F).

"(v) Antigens under subsection (s)(2)(G).

"(vi) Blood clotting factors for hemophiliacs under subsection (s)(2)(I).

"(vii) Services of a physician assistant under subsection (s)(2)(K)(ii).

"(viii) Pneumococcal, hepatitis B, or influenza vaccines under subsection (s)(10).

"(ix) Rural health clinic services (under subsection 1861(aa)(1)).

"(x) Comprehensive outpatient rehabilitation facility services (under subsection 1861(cc)(1)).

"(xi) Hospice care (as defined in subsection (dd)(1)).

"(xii) Certified nurse-midwife service (as defined in subsection (gg)(1)).

"(xiii) A covered surgical procedure in an ambulatory surgical center (under section 1832(a)(2)(F)(i)).

"(B) With respect to covered outpatient drugs dispensed in 1990, the term 'covered outpatient drug' is limited—

"(i) to drugs described in paragraph (2)(A) used in immunosuppressive therapy, and

"(ii) to covered home IV drugs (as defined in paragraph (4)).

"(C) The term 'covered outpatient drug' does not include a drug that is intravenously administered in a home setting unless it is a covered home IV drug.

"(4)(A) The term 'covered home IV drug' means a covered outpatient drug dispensed to an individual that—

"(i) is intravenously administered in a place of residence used as the individual's home, and

"(ii)(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or for the indication to which it is applied, that the drug cannot generally be administered safely and effectively in a home setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug and the indication for which the drug is being applied, that the drug can generally be administered safely and effectively in a home setting.

"(B) Not later than January 1, 1990 (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home IV drugs (as defined in subparagraph (A)), with respect to which home intravenous drug therapy may be provided under this title.".

(b) Deductible and Payment Amounts.—Part B is amended—

(1) in subsection (a)(1) of section 1833 (42 U.S.C. 1395l(b)), as amended by section 411(h)(7)(A)(v)(I) of this Act—

(A) by striking "and" before "(L)", and

(B) by adding at the end the following: "and (M) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under section 1834(c)(2)";

(2) in subsection (a)(2) of such section by inserting "(other than covered outpatient drugs)" after "(2) in the case of services";

(3) in subsection (b) of such section—

(A) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(B) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(3) by adding at the end of section 1834 (42 U.S.C. 1395m) the following new subsection:

"(c) Payment for Covered Outpatient Drugs.—

"(1) Deductible.—

"(A) APPLICATION.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), payment shall be made under paragraph (2) only with respect to expenses incurred by an individual for covered outpatient drugs during a calendar year on or after such date in the year as the Secretary determines that the individual has incurred expenses in the year for covered outpatient drugs (during a period in which the individual is entitled to benefits under this part) equal to the amount of the catastrophic drug deductible specified in subparagraph (C) for that year.

"(ii) DEDUCTIBLE NOT APPLIED FOR POST-HOSPITAL HOME INTRAVENOUS DRUG THERAPY.—The catastrophic drug deductible established under this paragraph shall not apply to covered home IV drugs dispensed in conjunction with home intravenous drug therapy services which are part of a continuous course of such therapy initiated while the individual was an inpatient in a hospital.

"(iii) DEDUCTIBLE NOT APPLIED TO 1ST YEAR IMMUNOSUPPRESSIVES.—The catastrophic drug deductible established under this paragraph shall not apply to drugs described in subsection (t)(2)(A) used in immunosuppressive therapy and furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant.

"(B) RESPONSE TO APPLICATION.—If the system described in section 1842(o)(4) has not been established and an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to the date (if any) as of which the individual has met such requirement.

"(C) CATASTROPHIC DRUG DEDUCTIBLE AMOUNT.—

"(i) IN GENERAL.—Subject to subparagraph (D), the catastrophic drug deductible specified in this subparagraph for—

"(I) 1990 is $550,

"(II) 1991 is $600,

"(III) 1992 is $652, and

"(IV) any succeeding year, is such an amount as the Secretary determines will result in 16.8 percent of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during that succeeding year having incurred expenses for covered outpatient drugs sufficient to meet the catastrophic drug deductible so determined.

"(ii) ROUNDING.—Any amount determined under this subparagraph which is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(iii) PUBLICATION.—Before May 1 of each year (beginning with 1992) the Secretary shall publish in the Federal Register a proposed regulation establishing the amount of the catastrophic drug deductible under this subparagraph for the following year. During the last 3 days of September of such year, the Secretary shall publish in the Federal Register the final regulation establishing the amount of such deductible for the following year, which amount may not be greater than the amount specified in the proposed regulation.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the catastrophic drug deductible established under paragraph (1)(A) and except as provided in subparagraph (C), the amounts payable under this part with respect to a covered outpatient drug is equal to the payment percent (specified in subparagraph (B)) of the lesser of—

"(i) the actual charge for the drug, or

"(ii) the applicable payment limit established under paragraph (3).

(B) PAYMENT PERCENT.—For purposes of subparagraph (A), the payment percent is 100 percent minus the applicable coinsurance percent (specified in subparagraph (C)).

"(C) COINSURANCE PERCENT.—For purposes of subparagraph (B), the coinsurance percent—

"(i) for covered home IV drugs and for drugs described in paragraph (1)(A)(iii) (relating to immunosuppressive therapy during 1st year after transplant), is 20 percent; and

"(ii) for other covered outpatient drugs dispensed—

"(I) in 1990 or 1991, is 50 percent,

"(II) in 1992 is 40 percent, and

"(III) in 1993 or a succeeding year is 20 percent.

"(D) TREATMENT OF CERTAIN COST-BASED PREPAID ORGANIZATIONS.—In applying subparagraph (A) in the case of an organization under a reasonable cost reimbursement contract under section 1876 and in the case of an organization receiving payment under section 1833(a)(1)(A) and providing coverage of covered outpatient drugs, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(3) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR NON-MULTIPLE SOURCE DRUGS AND MULTIPLE-SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that either is not a multiple source drug (as defined in paragraph (9)(A)) or is a multiple source drug and has a restrictive prescription (as defined in

paragraph (9)(B)), the payment limit for the drug under this paragraph for a payment calculation period is equal to the lesser of—

"(i) the 90th percentile of the actual charges (computed on a statewide basis, carrier-wide basis, or other appropriate geographic area basis, as specified by the Secretary) for the drug for the second previous payment calculation period, adjusted (as the Secretary determines to be appropriate) to reflect the number of tablets (or other dosage units) dispensed; or

"(ii) the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(I) the number of tablets (or other dosage units) dispensed, and

"(II) the per tablet or unit average wholesale price for such drug (as determined under subparagraph (C) for the period for purposes of this subparagraph);

except that clause (i) shall not apply to covered outpatient drugs dispensed before January 1, 1992.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(i) the number of tablets (or other dosage units) dispensed, and

"(ii) the unweighted median of the per tablet or unit average wholesale prices (determined under subparagraph (C) for purposes of this subparagraph) for such drug for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) IN GENERAL.—For purposes of this paragraph, the Secretary shall determine, with respect to the dispensing of a covered outpatient drug in a payment calculation period (beginning on or after January 1, 1990), the per tablet or unit average wholesale price for the drug.

"(ii) BASIS FOR DETERMINATIONS.—

"(I) DETERMINATION FOR NON-MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (A), such determination shall be based on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacies (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies); except that if, because of low volume of sales for the drug or other appropriate reasons or in the case of covered outpatient drugs during 1990, the Secretary determines that such a survey is not appropriate with respect to a specific drug, such determination

shall be based on published average wholesale (or comparable direct) prices for the drug.

"(II) DETERMINATION FOR MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (B), the Secretary may base the determination under this subparagraph on the published average wholesale (or comparable direct) prices for the drug or on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacists (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies).

"(III) COMPLIANCE WITH SURVEY REQUIRED.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide the information required in a survey under this clause, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to the survey shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part.

"(iii) QUANTITY AND TIMING.—Such determination shall be based on the price or prices for purchases in reasonable quantities and shall be made for a payment calculation period based on prices for the first day of the first month of the previous payment calculation period.

"(iv) GEOGRAPHIC BASIS.—The Secretary shall make such determination, and calculate the payment limits under this paragraph, on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale prices for a drug product.

"(4) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMITS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), for drugs dispensed in—

"(i) 1990 or 1991, the administrative allowance under this paragraph is—

"(I) $4.50 for drugs dispensed by a participating pharmacy, or

"(II) $2.50 for drugs dispensed by another pharmacy; or

"(ii) a subsequent year, the administrative allowance under this paragraph is the administrative allowance

under this paragraph for the preceding year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce in its 'Survey of Current Business') over the 12-month period ending with August of such preceding year.

Any allowance determined under the clause (ii) which is not a multiple of 1 cent shall be rounded to the nearest multiple of 1 cent.

"(B) ADJUSTMENT IN ALLOWANCE FOR MAIL SERVICE PHARMACIES.—The Secretary may, by regulation and after consultation with pharmacists, elderly groups, and private insurers, reduce the administrative allowances established under subparagraph (A) for any drug dispensed by a mail service pharmacy (as defined by the Secretary) based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(5) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

"(A) IN GENERAL.—The Secretary shall establish a program to identify (and to educate physicians and pharmacists concerning)—

"(i) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

"(ii) instances or patterns of substandard care with respect to such drugs, and

"(iii) potential adverse reactions.

"(B) STANDARDS.—In carrying out the program under subparagraph (A), the Secretary shall establish for each covered outpatient drug standards for the prescribing of the drug which are based on accepted medical practice. In establishing such standards, the Secretary shall incorporate standards from such current authoritative compendia as the Secretary may select; except that the Secretary may modify such a standard by regulation on the basis of scientific and medical information that such standard is not consistent with the safe and effective use of the drug.

"(C) PROHIBITION OF FORMULARY.—Nothing in this title (including paragraph (8)), other than sections 1861(t)(4)(A) and 1862(c), shall be construed as authorizing the Secretary to exclude from coverage or to deny payment—

"(i) for any specific covered outpatient drug, or specific class of covered outpatient drug, or

"(ii) for any specific use of such a drug for a specific indication unless such exclusion is pursuant to section 1862(a)(1) based on a finding by the Secretary that such use is not safe or is not effective.

"(6) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—

"(A) GENERAL RULE COUNTING PREPAID PLAN EXPENSES TOWARDS THE CATASTROPHIC DRUG DEDUCTIBLE.—Except as provided in subparagraph (B), expenses incurred by (or on behalf of) a medicare beneficiary for covered outpatient drugs shall be counted (consistent with subparagraph (C))

toward the catastrophic drug deductible established under paragraph (1) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876.

“(B) TREATMENT OF DRUG BUY-OUT PLAN EXPENSES.—In the case of a medicare beneficiary enrolled in a month in a drug buy-out plan (as defined in subparagraph (D))—

> *“(i) expenses incurred by the beneficiary for covered outpatient drugs reimbursed under the plan shall not be counted towards the catastrophic drug deductible, but*
>
> *“(ii) if the individual disenrolls from the plan during the year, the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for covered outpatient drugs in an amount equal to the actuarial value (with respect to such month) of the deductible for covered outpatient drugs (as computed by the Secretary for purposes of section 1876(e)(1)) applicable on the average to individuals in the United States.*

“(C) TREATMENT OF EXPENSES FOR COVERED OUTPATIENT DRUGS INCURRED WHILE ENROLLED IN A PREPAID PLAN OTHER THAN A DRUG BUY-OUT PLAN.—The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization which provides reimbursement for covered outpatient drugs, with respect to a plan that is not a drug buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that—

> *“(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred by (or on behalf of) enrollees under the plan for covered outpatient drugs; and*
>
> *“(ii) the organization will take into account, in any deductibles established under the plan in a year with respect to covered outpatient drugs under this part, the amounts of expenses for covered outpatient drugs incurred in the year by (or on behalf of) the beneficiary and otherwise counted towards the catastrophic drug deductible in the year.*

“(D) DRUG BUY-OUT PLAN DEFINED.—In this paragraph, the term ‘drug buy-out plan’ means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

> *“(i) the amount of any deductible under the plan with respect to covered outpatient drugs under this title,*

is less than 50 percent of—

> *“(ii) the catastrophic drug deductible specified in paragraph (1)(C).*

“(E) MEDICARE BENEFICIARY DEFINED.—In this subsection, the term ‘medicare beneficiary’ means, with respect to a month, an individual covered for benefits under this part for the month.

"(F) TREATMENT OF PLAN CHARGES.—In the case of covered outpatient drugs furnished by an eligible organization under section 1876(b) or an organization described in section 1833(a)(1)(A) which does not impose charges on covered outpatient drugs dispensed to its members, for purposes of this subsection the actual charges of the organization shall be the organization's standard charges to members, and other individuals, not entitled to benefits with respect to such drugs.

"(7) PHYSICIAN GUIDE.—

"(A) IN GENERAL.—The Secretary shall develop, and update annually, an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs. Such guide shall, to the extent practicable, group covered outpatient drugs (including multiple source drugs) in a manner useful to physicians by therapeutic category or with respect to the conditions for which they are prescribed. Such guide shall specify the average wholesale prices on the basis of the amount of the drug required for a typical daily therapeutic regimen.

"(B) MAILING GUIDE.—The Secretary shall provide for mailing, in January of each year (beginning with 1991), a copy of the guide developed and updated under subparagraph (A)—

"(i) to each hospital with an agreement in effect under section 1866,

"(ii) to each physician (as defined in section 1861(r)(1)) who routinely provides services under this part, and

"(iii) to Social Security offices, senior citizen centers, and other appropriate places.

"(8) REPORTS ON OUTLAYS AND RECEIPTS; SPECIAL COST CONTROLS.—

"(A) COMPILATION OF INFORMATION.—The Secretary shall compile information on—

"(i) manufacturers' prices for covered outpatient drugs, and on charges of pharmacists for covered outpatient drugs, and

"(ii) the use of covered outpatient drugs by individuals entitled to benefits under this part.

The information compiled under clause (i) shall include a comparison of the increases in prices and charges for covered outpatient drugs during each 6 month period (beginning with January 1987) with the semiannual average increase in such prices and charges during the 6 years beginning with 1981.

"(B) REPORTS.—The Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report, in May and November of 1989 and 1990 and in May of each succeeding year, providing the information compiled under subparagraph (A). For each such report submitted after 1991, the report shall in-

clude an explanation of the extent to which the increases in outlays for covered outpatient drugs under this part are due to the factors described in subparagraphs (A)(i) and (A)(ii).

"(C) MONTHLY REPORTS ON OUTLAYS AND RECEIPTS.—Within 30 days after the end of each month (beginning with October 1991 and ending with April 1993), the Secretary shall report to Congress on the outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund (in this paragraph referred to as the 'Trust Fund') in the month.

"(D) BUDGETARY INFORMATION.—

"(i) IN GENERAL.—In each report submitted under subparagraph (B) after 1991, the Secretary shall include information on—

"(I) the projected budgetary status of the Trust Fund for the succeeding year,

"(II) the projected increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(III) the projected level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(IV) the projected administrative costs relating to covered outpatient drugs.

"(ii) DETERMINATION AND PUBLICATION OF ANY OUTLAY CONTROLS FOR 1993 AND 1994.—For each such report in 1992 and 1993, the Secretary—

"(I) shall determine in the report whether the anticipated outlays and receipts of the Trust Fund for the succeeding year will provide for at least the minimum contingency margin specified in subparagraph (F) for that succeeding year, and

"(II) if not, shall include in the report (and shall publish in the Federal Register by May 1 of the year a proposed regulation to carry out) changes in the provisions of this part (consistent with subparagraph (E)) in order to reduce outlays from the Trust Fund in that succeeding year sufficiently to provide for the minimum contingency margin specified in subparagraph (F).

Any changes described in subclause (II) in such report shall reflect appropriately each of the anticipated causes of increased or unanticipated outlays for covered outpatient drugs.

"(iii) EFFECTIVENESS OF REGULATORY CHANGES.—If proposed regulations are published under clause (ii)(II) in 1992 or 1993, during the last 3 days of September of such year, the Secretary shall publish in the Federal Register a final regulation to implement the changes described in such clause. Notwithstanding any other provision of this part, but subject to subparagraph (E) and unless otherwise provided by law, such changes shall become effective on January 1 of the succeeding year and shall apply only during that succeeding year. Such final regulation may not revise the proposed regu-

lation in a manner that would result in a greater reduction in outlays than would have been the case under the proposed regulation.

"(E) LIMITATION ON CHANGES.—In making regulatory changes under subparagraph (D), the Secretary may not—

"(i) provide for a formulary (in violation of paragraph (5)(C));

"(ii) change the methodology for determining whether for a year an individual has met the catastrophic drug deductible established under paragraph (1)(A); or

"(iii) increase the coinsurance percent under paragraph (2)(C) for a year above the coinsurance percent in effect during the previous year.

Clause (ii) shall not be construed as prohibiting the Secretary from increasing the amount of the catastrophic drug deductible under paragraph (1)(A).

"(F) MINIMUM CONTINGENCY MARGIN DEFINED.—In this paragraph, the term 'minimum contingency margin' means—

"(i) for 1993, 50 percent, and

"(ii) for 1994, 25 percent.

Such margin shall be determined as of the close of each calendar year and shall be determined based on the total outlays from the Trust Fund during the year.

"(9) DEFINITIONS.—In this subsection:

"(A) MULTIPLE SOURCE DRUG.—

"(i) IN GENERAL.—The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations',

"(II) except as provided in clause (ii), are pharmaceutically equivalent and bioequivalent, as defined in clause (iii) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed during the period.

"(ii) EXCEPTION.—Subclause (II) of clause (i) shall not apply if the Food and Drug Administration changes by regulation (after an opportunity for public comment of 90 days) the requirement that, for purposes of the publication described in clause (i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in clause (iii).

"(iii) DEFINITIONS.—For purposes of this subparagraph:

"(I) PHARMACEUTICALLY EQUIVALENT.—Drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form

and meet compendial or other applicable standards of strength, quality, purity, and identity.

"(II) Bioequivalent.—Drugs are bioequivalent if they do not present a known or potential bioequivalence problem or, if they do present such a problem, are shown to meet an appropriate standard of bioequivalence.

"(III) Sold or marketed.—A drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i)(I), unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) Restrictive prescription.—A drug has a 'restrictive prescription' only if—

"(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that the particular drug must be dispensed, or

"(ii) in the case of a prescription issued by telephone—

"(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that the particular drug must be dispensed, and

"(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug was required to have been dispensed.

"(C) Payment calculation period.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year.

"(D) Outlays; receipts.—The terms 'outlays' and 'receipts' mean, with respect to a year or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such year or other period.".

(c) Participating Pharmacies; Civil Money Penalties.—

(1) Participating pharmacies.—Section 1842 (42 U.S.C. 1395t) is amended—

(A) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: ", except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (o)(1))";

(B) in subsection (h)(4), is amended by adding at the end the following: "In publishing directories under this para-

graph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies."; and

(C) by adding at the end the following new subsection:

"(o)(1) For purposes of this section, the term 'participating pharmacy' means, with respect to covered outpatient drugs dispensed on or after January 1, 1991, an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees to accept payment under this part on an assignment-related basis for all covered outpatient drugs dispensed to an individual entitled to benefits under this part (in this subsection referred to as 'medicare beneficiaries') during a year after—

"(i) the Secretary has notified the entity, through the electronic system described in subparagraph (D)(i), or

"(ii) in the absence of such a system, the entity is otherwise notified that the Secretary has determined,

that the individual has met the catastrophic drug deductible with respect to such drugs under section 1834(c)(1) for the year.

"(B) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any medicare beneficiary, and

"(ii) not to charge medicare beneficiaries (regardless of whether or not the beneficiares are enrolled under a prepaid health plan or with eligible organization under section 1876) more for such drugs than the amount it charges to the general public (as determined by the Secretary in regulations).

"(C) The entity agrees to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to all medicare beneficiaries.

"(D) The entity agrees to submit information (in a manner specified by the Secretary to be necessary to administer this title) on all purchases of covered outpatient drugs dispensed to medicare beneficiaries.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information (consistent with State law respecting the provision of such information) to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(F) The entity agrees to provide the information requested by the Secretary in surveys under section 1834(c)(3)(C)(ii).

Nothing in this paragraph shall be construed as requiring a pharmacy operated by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) for the exclusive benefit of its members to dispense covered outpatient drugs to individuals who are not members of the organization.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) upon request, such electronic equipment and technical assistance (other than the costs of obtaining, maintaining, or expanding telephone service) as the Secretary determines may be necessary for the pharmacy to submit claims using the electronic system established under paragraph (4).

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure—

"(A) compliance with the requirements for participation under this title, and

"(B) the accuracy of information submitted by the pharmacies under this title.

"(4) The Secretary shall establish, by not later than January 1, 1991, a point-of-sale electronic system for use by carriers and participating pharmacies in the submission of information respecting covered outpatient drugs dispensed to medicare beneficiaries under this part.

"(5) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(2) CIVIL MONEY PENALTIES FOR VIOLATION OF PARTICIPATION AGREEMENT, FOR EXCESSIVE CHARGES FOR NONPARTICIPATING PHARMACIES AND FOR FAILURE TO PROVIDE SURVEY INFORMATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking "or" at the end of paragraph (1),

(B) in paragraph (2)(C), by inserting "or to be a participating pharmacy under section 1842(o)" after "1842(h)(1)",

(C) by striking ", or" at the end of paragraph (2) and inserting a semicolon,

(D) by adding "or" at the end of paragraph (3), and

(E) by inserting after paragraph (3) the following new paragraph:

"(4) in the case of a participating or nonparticipating pharmacy (as defined for purposes of part B of title XVIII)—

"(A) presents or causes to be presented to any person a request for payment for covered outpatient drugs dispensed to an individual entitled to benefits under part B of title XVIII and for which the amount charged by the pharmacy is greater than the amount the pharmacy charges the general public (as determined by the Secretary in regulations), or

"(B) fails to provide the information requested by the Secretary in a survey under section 1834(c)(3)(C)(ii);".

(d) LIMITATION ON LENGTH OF PRESCRIPTION.—Section 1862(c) (42 U.S.C. 1395y(c)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (1) as clauses (i) through (iv), respectively;

(2) in paragraph (2)(A), by striking "paragraph (1)" and inserting "subparagraph (A)";

(3) by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(4) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(5) by inserting "(1)" after "(c)"; and

(6) by adding at the end the following new paragraph:

"(2) No payment may be made under part B for any expense incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days or such longer period of time (not to exceed 90 days, except in exceptional circumstances) as the Secretary may authorize.".

(e) USE OF CARRIERS, FISCAL INTERMEDIARIES, AND OTHER ENTITIES IN ADMINISTRATION.—

(1) AUTHORIZING USE OF OTHER ENTITIES IN ELECTRONIC CLAIMS SYSTEM.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by adding at the end the following new paragraph:

"(3) with respect to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), a voluntary association, corporation, partnership, or other nongovernmental organization, which the Secretary determines to be qualified to conduct such activities.".

(2) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c) of this Act, is amended—

(A) by striking "and" at the end of subparagraph (H), and

(B) by inserting after subparagraph (I) the following new subparagraphs:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) receive information transmitted under the electronic system established under subsection (o)(4), and

"(ii) respond to requests by participating pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the catastrophic drug deductible established under section 1834(c)(1)(A) for a year; and

"(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system established under subsection (o)(4) for covered outpatient drugs under this part;".

(3) SPECIAL CONTRACT PROVISIONS FOR ELECTRONIC CLAIMS SYSTEM.—

(A) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) is amended—

(i) by inserting "(i)" after "(c)(1)(A)",

(ii) in the first sentence, by inserting ", except as provided in clause (ii)," after "under this part, and", and

(iii) by adding at the end the following new clause:

"(ii) To the extent that a contract under this section provides for implementation and operation (and related functions) of the electronic system established under subsection (o)(4) for covered outpatient drugs, the Secretary may provide for payment for such activi-

ties based on any method of payment determined by the Secretary to be appropriate.".

(B) APPLICATION OF DIFFERENT PERFORMANCE STANDARDS.—The Secretary of Health and Human Services, before entering into contracts under section 1842 of the Social Security Act with respect to the implementation and operation (and related functions) of the electronic system for covered outpatient drugs, shall establish standards with respect to performance with respect to such activities. The provisions of section 1153(e)(2), and paragraphs (1) and (2) of section 1153(h), of such Act shall apply to such activities in the same manner as they apply to contracts with peer review organizations, instead of the requirements of the last 2 sentences of section 1842(b)(2) of such Act.

(C) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to activities relating to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis.".

(4) ADJUSTMENT OF CARRIER OBLIGATIONS.—

(A) NO TOLL-FREE TELEPHONE NUMBER REQUIRED OF LIMITED CARRIERS.—Section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(B) DELAY IN APPLICATION OF COORDINATED BENEFITS WITH MEDIGAP.—The provisions of subparagraph (B) of section 1842(h)(3) of the Social Security Act shall not apply to covered outpatient drugs (other than drugs described in section 1861(s)(2)(J) of such Act as of the date of the enactment of this Act) dispensed before January 1, 1993.

(5) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking "Each" and inserting "Except as provided in paragraph (3), each";

(B) by adding at the end the following new paragraph:

"(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim.

"(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.".

(f) MODIFICATION OF HMO/CMP CONTRACTS.—

(1) SEPARATE ACTUARIAL DETERMINATION FOR COVERED OUTPATIENT DRUG BENEFIT.—Section 1876(e)(1) (42 U.S.C. 1395mm(e)(1)) is amended by adding at the end thereof the following new sentence: "The preceding sentence shall be applied separately with respect to covered outpatient drugs.".

(2) ADDITIONAL OPTIONAL BENEFITS.—Section 1876(g)(3)(A) (42 U.S.C. 1395mm(g)(3)(A)) is amended by striking "rate" and inserting "rates".

(g) REQUIRING SUBMISSION OF DIAGNOSTIC INFORMATION.—Section 1842 (42 U.S.C. 1395u), as amended by subsection (c)(1)(D), is amended by adding at the end the following new subsection:

"(p)(1) Each request for payment, or bill submitted, for an item or service furnished by a physician for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

"(2) In the case of a request for payment for an item or service furnished by a physician on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

"(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

"(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a carrier, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

"(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in section 1842(j)(2)(A).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

(h) CONFORMING AMENDMENTS.—

(1) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) by inserting "1834(c)," after "1833(b)," and

(B) by inserting "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1834(c)(2)(C)) of the lesser of the actual charges for the drugs or the payment limit (established under section 1834(c)(3))" after "established by the Secretary".

(2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5)) is amended by striking "section 1862(c)" and inserting "section 1862(c)(1)".

(i) REPORTS ON MEDICARE BENEFICIARY DRUG EXPENSES.—

(1) HHS.—The Secretary of Health and Human Services, by not later than April 1, 1989—

(A) using data from the 1987 National Medical Expenditures Survey (conducted by the National Center for Health Services Research and Health Care Technology Assessment), shall report to Congress on expenses incurred by *medicare beneficiaries for outpatient prescription drugs, and*

(B) shall provide the Director of the Congressional Budget Office with such data from that Survey as the Director may request to make the estimates required under paragraph (2).

(2) Reestimation of costs.—The Director of the Congressional Budget Office shall transmit to the Congress, not later June 1, 1989, or, if later, 60 days after the date of providing data requested under paragraph (1)(B), the Director's estimate of the outlays which will be made (in each of fiscal years 1990, 1991, 1992, and 1993) under the medicare program for covered outpatient drugs (under the amendments made by this section).

(j) Prescription Drug Payment Review Commission.—Part B is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"Sec. 1847. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1989, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary.

"(b)(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1990, concerning methods of determining payment for covered outpatient drugs under this part.

"(2) Such report, in 1992 and thereafter, shall include, with respect to the previous year, information on—

"(A) increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(B) the level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(C) administrative costs relating to covered outpatient drugs.

"(3) Such report, in 1992 and thereafter, shall include comments on the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for any reductions in outlays that may be required to achieve the contingency margin (established under section 1841A(d) for the following year, taking into account

each of the causes of increased or unanticipated outlays for covered outpatient drugs in the year.

"(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Catastrophic Drug Insurance Trust Fund.".

(k) ADDITIONAL STUDIES.—

(1) HHS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct the following studies, and report to Congress on the results of each such study by the following dates:

(A) A study of the possibility of including drugs which have not yet been approved under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act and biological products which have not been licensed under section 351 of the Public Health Service Act but which are commonly used in the treatment of cancer or in immunosuppressive therapy and other experimental drugs and biological products as covered outpatient drugs under the medicare program, for which a report shall be made by January 1, 1990. The study under this subparagraph shall be conducted in consultation with an advisory board of consumers, experts in the fields of cancer chemotherapy and immunosuppressive therapy, representatives of pharmaceutical manufacturers, and such other individuals as the Secretary may select.

(B) A study to evaluate the potential to use mail service pharmacies to reduce costs to the medicare program and to medicare beneficiaries, for which a report shall be made by January 1, 1990.

(C) A study of methods to improve utilization review of covered outpatient drugs, for which the report shall be made by January 1, 1993.

(D) A longitudinal study, to be conducted as a follow-up to the data collected under the survey referred to in subsection (j)(1)(A), on the use of outpatient prescription drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage, for which a report shall be made by January 1, 1993.

(2) GAO.—The Comptroller General shall conduct the following studies, and report to Congress on the results of each such study by not later than May 1, 1991:

(A) A study comparing average wholesale prices with actual pharmacy acquisition costs by type of pharmacy.

(B) A study to determine the overhead costs of retail pharmacies.

(C) A study of the discounts given by pharmacies to other third-party insurers.

Pharmacies which fail to provide the Comptroller General with reasonable access to necessary records to carry out the studies under this paragraph are subject to exclusion from the medi-

care and medicaid programs under section 1128(a) of the Social Security Act.

(l) Development of Standard Medicare Claims Form.—

(1) The Secretary shall develop, in consultation with representatives of pharmacies and other interested individuals, a standard claims form (and a standard electronic claims format) to be used in requests for payment for covered outpatient drugs under the medicare program and other third-party payors.

(2) Not later than October 1, 1989, the Secretary shall distribute official sample copies of the format developed under paragraph (1) to pharmacies and other interested parties and by not later than October 1, 1990, shall distribute official sample copies of the form developed under paragraph (1) to pharmacies and other interested parties.

(m) Effective Dates.—

(1) In general.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to items dispensed on or after January 1, 1990.

(2) Carriers.—The amendments made by subsection (e) shall take effect on the date of the enactment of this Act; except that the amendments made by subsection (e)(5) shall take effect on January 1, 1991, but shall not be construed as requiring payment before February 1, 1991.

(3) HMO/CMP enrollments.—The amendment made by subsection (f) shall apply to enrollments effected on or after January 1, 1990.

(4) Diagnostic coding.—The amendment made by subsection (g) shall apply to services furnished after March 31, 1989.

(5) Transition.—With respect to administrative expenses (and costs of the Prescription Drug Payment Review Commission) for periods before January 1, 1990, amounts otherwise payable from the Federal Catastrophic Drug Insurance Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund and shall also be treated as a debit to the Medicare Catastrophic Coverage Account.

SEC. 203. COVERAGE OF HOME INTRAVENOUS DRUG THERAPY SERVICES.

(a) In General.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home intravenous drug therapy services" before the semicolon.

(b) Home Intravenous Drug Therapy Services Defined.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"(jj)(1) The term 'home intravenous drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as such individual's home;

"(B) by a qualified home intravenous drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by such provider; and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies,

intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively an intravenously administered drug regimen through use of a covered home IV drug (as defined in subsection (t)(4)), but do not include such covered outpatient drugs.

“(3) The term ‘qualified home intravenous drug therapy provider’ means any entity that the Secretary determines meets the following requirements:

“(i) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home IV drugs.

“(ii) The entity maintains clinical records on all patients.

“(iii) The entity adheres to written protocols and policies with respect to the provision of items and services.

“(iv) The entity makes services available (as needed) seven days a week on a 24-hour basis.

“(v) The entity coordinates all services with the patient’s physician.

“(vi) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

“(vii) The entity assures that only trained personnel provide covered home IV drugs (and any other service for which training is required to safely provide the service).

“(viii) The entity assumes responsibility for the quality of services provided by others under arrangements with the agency or entity.

“(ix) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, (I) is licensed pursuant to such law, or (II) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

“(x) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of the home intravenous drug therapy benefit.”.

(c) PAYMENT.—

(1) IN GENERAL.—Part B is amended—

(A) in subsection (a)(2)(B) of section 1833 (42 U.S.C. 1395l), by striking “or (E)” and inserting “(E), or (F)”;

(B) in subsection (a)(2)(D) of such section, by striking “and” at the end;

(C) in subsection (a)(2)(E) of such section, by striking the semicolon and inserting “; and”;

(D) by inserting after subsection (a)(2)(E) of such section the following new subparagraph:

“(F) with respect to home intravenous drug therapy services, the amounts described in section 1834(d)(1);”

(E) in subsection (b) of such section, by striking “services, (3)” and inserting “services and home intravenous drug therapy services, (3)”; and

(F) by adding at the end of section 1834, as amended by section 202(b)(3) of this Act, the following new subsection:

"(d) HOME INTRAVENOUS DRUG THERAPY SERVICES.—

"(1) IN GENERAL.—With respect to home intravenous drug therapy services, subject to paragraph (3), payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

"(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of calendar year 1990 and each succeeding calendar year a fee schedule for home intravenous drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

"(3) LIMITATION ON ACCEPTANCE OF, AND PAYMENTS FOR, CERTAIN REFERRALS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a home intravenous drug therapy provider may not provide home intravenous drug therapy services under this part to an individual if the individual's referring physician (as defined in subparagraph (D)), or an immediate family member of the physician—

"(i) has an ownership interest in the provider, or

"(ii) receives compensation from the provider.

"(B) EXCEPTIONS.—

"(i) Subparagraph (A)(i) shall not apply—

"(I) if the ownership interest is the ownership of stock which is traded over a publicly-regulated exchange and was purchased on terms generally available to the public, or

"(II) if the provider is a sole home intravenous drug therapy provider (as defined by the Secretary) in a rural area.

"(ii) Subparagraph (A)(ii) shall not apply if the compensation is reasonably related to items or services actually provided by the physician and does not vary in proportion to the number of referrals made by the referring physician, but such exception shall not apply to compensation provided for direct patient care services.

"(iii) Subparagraph (A) shall not be construed to apply to a referring physician whose only ownership or financial relationship with the provider is as an uncompensated officer or director of the provider.

"(iv) Subparagraph (A) also shall not apply in such cases, established by the Secretary in regulations, in which the nature of the ownership or compensation does not pose a substantial risk of program abuse.

"(C) SANCTIONS.—

"(i) DENIAL OF PAYMENT.—No payment may be made under this part for home intravenous drug therapy services which are provided in violation of subparagraph (A).

"(ii) CIVIL MONEY PENALTY FOR IMPROPER CLAIMS.—Any person (including a home intravenous drug therapy provider or physician) that presents or causes to be presented a claim for an item or service that such

person knows or should know is for an item or service for which payment may not be made under subparagraph (A) shall be subject to a civil money penalty of not more than $15,000 for each such item or service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) REFERRING PHYSICIAN DEFINED.—In this paragraph, the term 'referring physician' means, with respect to providing home intravenous drug therapy services to an individual, a physician who—

"(i) prescribed the covered home IV drug for which the services are to be provided, or

"(ii) established the plan of care for such services.".

(2) PROPAC STUDY.—The Prospective Payment Assessment Commission shall conduct a study, and make recommendations to Congress and the Secretary of Health and Human Services by not later than March 1, 1991, concerning appropriate adjustment to the payment amounts provided under section 1886(d) of the Social Security Act for inpatient hospital services to account for reduced costs to hospitals resulting from the amendments made by this section.

(3) INSPECTOR GENERAL REPORT ON POTENTIALLY ABUSIVE OWNERSHIP OR COMPENSATION ARRANGEMENTS.—The Inspector General of the Department of Health and Human Services shall study and report to Congress, by not later than May 1, 1989, concerning—

(A) physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the medicare program;

(B) the range of such arrangements and the means by which they are marketed to physicians;

(C) the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and

(D) the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current anti-kickback provisions.

Such report shall include such recommendations as may be appropriate to strengthen current law provisions to prevent program abuse.

(d) CERTIFICATION.—

(1) IN GENERAL.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by inserting after subparagraph (F) the following new subparagraph:

"(G) in the case of home intravenous drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home IV drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, (iv) such services are administered in a place of residence used as such individual's home, and (v) with respect to such services initiated before January 1, 1993, such services have been reviewed and approved by a utilization and peer review organization under section 1154(a)(16) before the date such services were initiated (or, in the case of services first initiated on an outpatient basis, within 1 working day (except in exceptional circumstances) of the date of initiation of the services).".

(2) PRO PRIOR APPROVAL REQUIRED.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

"(16) The organization shall perform the review described in paragraph (1) with respect to home intravenous drug therapy services (as defined in section 1861(jj)(1)) initiated before January 1, 1993, within 1 working day of the date of the organization's receipt of a request for such review. The Secretary shall establish criteria to be used by such an organization in conducting reviews with respect to the appropriateness of home intravenous drug therapy services under this paragraph.".

(e) CERTIFICATION OF HOME INTRAVENOUS DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting "home intravenous drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (jj)(3)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by inserting "or a home intravenous drug therapy provider," after "hospice program", and

(B) in the second sentence, by striking "or hospice program" and inserting "hospice program, or home intravenous drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w-2) is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS" at the end;

(B) in subsection (a), by inserting "or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(jj)(3)" after "under this part"; and

(C) in subsection (b)(2)(A)(iv) by inserting "or home intravenous drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end thereof the following new subsection:

"(k) With respect to carrying out functions relating to payment for home intravenous drug therapy services and covered home IV drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990.

SEC. 204. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) by redesignating paragraphs (13) and (14) as paragraphs (14) and (15), respectively,

(B) by striking "and" at the end of paragraph (11),

(C) by striking the period at the end of paragraph (12) and inserting "; and", and

(D) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (kk)).''; and

(2) by adding at the end the following new subsection:

"Screening Mammography

"(kk) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.".

(b) PAYMENT AND COVERAGE.—Section 1834 (42 U.S.C. 1395m), as amended by sections 202(b)(3) and 203(c)(1)(F) of this Act, is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (e)(1)(A)" after "conversion factors", and

(2) by adding at the end the following new subsection:

"(e) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part (except as provided in section 1833(c)), with respect to expenses incurred for screening mammography (as defined in section 1861(kk))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

"(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

"(i) the actual charge for the screening,

"(ii) the fee schedule established under subsection (b) with respect to both the professional and technical *components of the screening mammography, in the case of screening mammography subject to such schedule but for this paragraph, or*

"(iii) the limit established under paragraph (4) for the screening mammography.

"(2) Frequency covered.—

"(A) In general.—Subject to revision by the Secretary under subparagraph (B)—

"(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

"(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

"(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months of a previous screening mammography, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months after a previous screening mammography.

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months after a previous screening mammography.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months after a previous screening mammography.

"(B) Revision of frequency.—

"(i) Review.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

"(ii) Revision of frequency.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

"(3) Quality standards.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

"(4) LIMIT.—

"(A) $50, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1990, is $50, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1991, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

"(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1990, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or, if applicable and if less, as defined in subsection (b)(5)(B)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—

"(i) in 1990, 125 percent of the limit established under paragraph (4),

"(ii) in 1991, 120 percent of the limit established under paragraph (4), and

"(iii) after 1991, 115 percent of the limit established under paragraph (4).

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 (42 U.S.C. 1395z) is amended by inserting "or whether screening mammography meets the standards established under section 1834(e)(3)," after "1832(a)(2)(F)(i),".

(2) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: ", or whether screening mammography meets the standards established under section 1834(e)(3)".

(3) Section 1865(a) (42 U.S.C. 1395bb(a)) is amended by inserting "1834(e)(3)," after "1832(a)(2)(F)(i),".

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ", but excluding screening mammography" after "imaging services".

(2) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(e)(2) or which does not meet the standards established under section 1834(e)(3);"; and

(B) in paragraph (7), by inserting "or under paragraph (1)(F)" after "(1)(B)".

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (13) and (14)" and inserting "paragraphs (14) and (15)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1990. Paragraph (5) of section 1834(e) of the Social Security Act shall only apply until such time as the Secretary of Health and Human Services implements the physician fee schedules based on relative value scale developed under section 1845(e) of such Act.

(f) REPORTS.—

(1) The Physician Payment Review Commission shall study and report, by July 1, 1989, to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate concerning the cost of providing screening mammography in a variety of settings and at different volume levels.

(2) The Comptroller General shall study and report, by July 1, 1989, to the Committees specified in paragraph (1) concerning the quality of care of screening mammography in a variety of settings.

SEC. 205. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) in paragraph (2)(A)—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the semicolon at the end the following: ", and (ii) in-home care for a chronically dependent individual for up to 80 hours in any 12-month period described in section 1861(ll)(4), but not to exceed 80 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 204(a)(2), is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ll)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.

"(4) The 12-month period described in this paragraph is the 1-year period beginning on the date that the Secretary determines that a chronically dependent individual either—

"(A) has become entitled to benefits under section 1833(c) (relating to having incurred out-of-pocket part B cost sharing equal to the part B catastrophic limit), or

"(B) has become entitled to have payments made for covered outpatient drugs under section 1834(c).

In the case of an individual who qualifies under subparagraph (A) or (B) within 12 months after previously qualifying, the subsequent qualification shall begin a new 12-month period under this paragraph. In the case of an individual enrolled in a buy-out plan (as defined in section 1833(c)(5)(D)) or a drug buy-out plan (as defined in section 1834(c)(6)(D)), the Secretary shall establish such procedures as may be appropriate to identify individuals who are deemed to be described in subparagraph (A) or (B), respectively, for purposes of the provision of in-home care under the plan.

(c) Payment.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.".

(d) Certification.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)), as amended by section 203(d), is amended—

(1) by striking "and" at the end of subparagraph (F);

(2) by striking the period at the end of subparagraph (G) and inserting in lieu thereof "; and"; and

(3) by inserting after subparagraph (G) the following new subparagraph:

"(H) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.".

(e) Standards for Utilization.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 204(d)(2), is amended—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (E),

(ii) by adding "and" at the end of subparagraph (F), and

(iv) by adding at the end the following new subparagraph:

"(G) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section.

(f) Effective Date.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990.

(g) Study of Alternative Out-of-Home Services.—The Secretary of Health and Human Services shall study, and report to Congress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care.

SEC. 206. EXTENDING HOME HEALTH SERVICES.

(a) In General.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.".

(b) Effective Date.—The amendment made by subsection (a) shall apply to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990.

SEC. 207. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) In General.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) Authorization of Appropriations.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1989, 1990, 1991, 1992, and 1993 to carry out the research described in subsection (a).

(c) Long-Term Care Services Defined.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

(d) Reports.—The Secretary of Health and Human Services shall submit interim reports by December 1, 1990, and by December 1, 1992, and a final report by June 1, 1994, concerning the demonstration projects conducted under this section.

SEC. 208. STUDY OF ADULT DAY CARE SERVICES.

(a) Survey of Current Adult Day Care Services.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) Report.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under

medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

Subtitle B—Medicare Part B Monthly Premium Financing

SEC. 211. ADJUSTMENT IN MEDICARE PART B PREMIUM.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g)(1)(A) Except as provided in this paragraph, paragraphs (4) and (5), and subsections (b) and (f), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of the catastrophic coverage monthly premium and the prescription drug monthly premium for months in the year determined under the following table (for months occurring in 1989 through 1993) or determined in accordance with paragraphs (2) and (3) (for months after December 1993):

"In the case of:	*The catastrophic coverage monthly premium is:*	*The prescription drug monthly premium is:*
1989	*$4.00*	*0*
1990	*$4.90*	*0*
1991	*$5.46*	*$1.94*
1992	*$6.75*	*$2.45*
1993	*$7.18*	*$3.02*

"(B)(i) Except as provided in subparagraph (C), if the amount of the supplemental premium rate otherwise determined under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in a calendar year is increased as a result of subsection (e)(2)(A)(i) of such section or is reduced as a result of subsection (e)(2)(A)(ii) of such section, the monthly premium increase otherwise determined under this paragraph shall be reduced or increased, respectively, by an amount equal to—

"(I) $\frac{1}{12}$th of the excess or shortfall, respectively, determined under clause (ii) for the year, as adjusted under clause (iv), divided by

"(II) the average number of individuals covered under this part during the preceding year.

"(ii) The excess or shortfall determined under this clause for a year is the excess or shortfall, determined by the Secretary of the Treasury, of—

"(I) the total amount of the supplemental premiums imposed under section 59B of the Internal Revenue Code of 1986 in the 2nd preceding year, over

"(II) the total amount of such premiums which would have been imposed in such year if the supplemental premium rate under such section had been increased by the shortfall rate, or decreased by the excess rate, described in clause (iii).

"(iii) The excess rate or shortfall rate under this clause for a year is the excess or shortfall of—

"(I) the supplemental premium rate established under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the year, and

"(II) the amount of such supplemental rate if determined without regard to subsection (e)(2)(A) of such section.

"(iv) The amount determined under clause (i)(I) for a year shall be increased by the percentage by which the per capita catastrophic coverage premium liability (as determined in section 59B(e)(3)(D)(ii) of the Internal Revenue Code of 1986) for the second preceding year exceeds such liability for the fourth preceding year (determined as if the catastrophic coverage premium rate for the second preceding calendar year were the same as the rate in effect for the fourth preceding calendar year).

"(C) In no event shall the monthly premium increase in effect under this paragraph for months in a year after 1993 be less than the monthly premium increase in effect under this paragraph for months in the preceding year.

"(D) If subparagraph (B) or subparagraph (C), or both, affects the increase in the monthly premium determined under this paragraph for a year, the increase in the monthly premium determined after the application of such subparagraph or subparagraphs shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of either such subparagraph.

"(2)(A) In the case of months in a year after 1993, the catastrophic coverage monthly premium is the catastrophic coverage monthly premium (in effect under paragraph (1) or this paragraph for months in the preceding year, determined without regard to paragraph (1)(B) or (1)(C)) adjusted by the percentage determined under subparagraph (B) for the year.

"(B) The percentage determined under this subparagraph for a year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(C)(i) Except as provided in clause (ii), the outlay-premium percentage for any year is the percentage by which—

"(I) the per capita catastrophic outlays in the 2nd preceding year exceeds

"(II) such outlays in the 3rd preceding calendar year.

If there is no excess, this clause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for any year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(D)(i) The reserve account percentage for any calendar year is the percentage which the premium change determined under clause (ii) is of the catastrophic coverage monthly premium in effect under paragraph (1) or this paragraph for the preceding year (determined without regard to paragraph (1)(B) or (1)(C)). If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) The premium change determined under this clause for any year is the adjustment in the catastrophic coverage monthly premium (otherwise in effect for the 2nd preceding year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this subsection for such year equal to 37 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) The shortfall (or excess) determined under this clause for any year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this paragraph or section 59B(e) of the Internal Revenue Code of 1986 which have not been credited into such Account).

"(3) In the case of months in a year after 1993, the prescription drug monthly premium shall be determined under rules similar to the rules of paragraph (2); except that—

"(A) in determining the prescription drug monthly premium for any month in a year before 1998, the following percentages shall be substituted for 20 percent in paragraph (2)(D)(iii)(I):

"In the case of year:	*The percentage is:*
1994	*75*
1995	*50*
1996	*25*
1997	*25;*

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998;

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund, and

"(D) any reference to the catastrophic coverage monthly premium shall be treated as a reference to the prescription drug monthly premium.

"(4)(A) In the case of an individual who is a resident of Puerto Rico or who is a resident of another U.S. commonwealth or territory during a month, instead of the premium increase provided under paragraph (1), subject to subsection (b), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for such resident for the year, and—

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the resident for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1989 is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory;

"(ii) in 1990 is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the catastrophic coverage monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita catastrophic outlays for the year, will exceed

"(II) the per capita catastrophic outlays for that preceding year.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory;

"(ii) in 1991 is $1.21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the prescription drug monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita prescription drug outlays for the year, will exceed

"(II) the per capita prescription drug outlays for that preceding year.

"(5)(A) In the case of a part B only individual (as defined in paragraph (8)(F)) during a month, instead of the premium increase provided under paragraph (1), subject to subsection (b), the monthly premium otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for the year, and—

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1990 is $8.57, and

“(ii) in a subsequent year is $\frac{1}{12}$th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs (other than benefits and costs attributable to part A) for which outlays may be made from the Medicare Catastrophic Coverage Account.

“(C) The prescription drug monthly premium for months—

“(i) in 1990 is $0.53,

“(ii) in 1991 is $4.61, and

“(iii) a subsequent year is $\frac{1}{12}$th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs for which outlays may be made from the Federal Catastrophic Drug Insurance Trust Fund.

“(6)(A) If any premium increase for a month under this subsection is not a multiple of 10 cents, the Secretary shall round the increase to the nearest multiple of 10 cents.

“(B) If the Secretary so rounds the premium increase, the amount of such increase shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of subparagraph (A).

“(7)(A) The Secretary and the Secretary of the Treasury shall jointly—

“(i) publish in the Federal Register by not later than July 1 of each year (beginning with 1993) a proposed regulation to establish premium increases under this subsection for months in the following year,

“(ii) report to Congress, by not later than September 1 of such year, on the final premiums to be published under clause (iii), and

“(iii) publish in the Federal Register, during the last 3 days of September of each such year, a final regulation establishing monthly premiums under this subsection for months in the following year.

“(B) The Secretary shall report to Congress, in 1993, respecting the appropriateness of the level of premium increases established under paragraph (4) for residents of Puerto Rico and of other U.S. commonwealths and territories.

“(8) For purposes of this subsection:

“(A) The term ‘per capita catastrophic outlays’ means, with respect to any year, the amount (as determined by the Secretary) equal to—

“(i) the outlays during such year from the Medicare Catastrophic Coverage Account, divided by

“(ii) the average number of individuals entitled to receive benefits under part A during such year.

“(B) The term ‘per capita prescription drug outlays’ means, with respect to any year, the amount (as determined by the Secretary) equal to—

“(i) the outlays during such year from the Federal Catastrophic Drug Insurance Trust Fund, divided by

“(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(C) The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5) of the Internal Revenue Code of 1986) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(D) The term 'Medicare Catastrophic Coverage Account' refers to such Account as created under section 1841B.

"(E) The term 'U.S. commonwealth or territory' means Puerto Rico, the United States Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(E) The term 'part B only individual' means, with respect to a month, an individual who—

> *"(i) is not a resident of a U.S. commonwealth or territory (as defined in subparagraph (D)) during the month,*
>
> *"(ii) is entitled to benefits under this part, and*
>
> *"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A or is entitled to benefits under such part only because of payment of a premium under section 1818.".*

(b) Extension of Hold-Harmless Provision.—Subsection (f) of section 1839 is amended to read as follows:

"(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that January below the amount of benefits payable to that individual for that December (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.".

(c) Conforming Amendments.—

> *(1) Section 1839 (42 U.S.C. 1395r) is amended—*
>
> > *(A) in the second sentence of subsections (a)(1) and (a)(4), by inserting "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)" before the period;*
> >
> > *(B) by inserting before the period at the end of the last sentence of subsections (a)(1) and (a)(4) the following: ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account";*
> >
> > *(C) in subsections (a)(2), by striking "and (e)" and inserting ", (e), and (g)";*
> >
> > *(D) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";*

(E) in subsection (b), by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsections (f) and (g)(6))"; and

(F) in subsection (e)(1), by inserting "except as provided in subsection (g)," after "subsection (a)".

(2) Section 1844(a) (42 U.S.C. 1395w(a)(1)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) or section 59B of the Internal Revenue Code of 1986.".

(3) Section 1876(a)(5) (42 U.S.C. 1395ff(a)(5)) is amended—

(A) by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", the Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund", and

(B) by amending the second sentence to read as follows: "The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

"(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

"(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.".

(d) Effective Date.—The amendments made by this section shall apply (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989.

SEC. 212. ESTABLISHMENT OF FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND; FUND TRANSFERS.

(a) In General.—Part B of title XVIII is amended by inserting after section 1841 the following new section:

"FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND

"Sec. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Catastrophic Drug Insurance Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts transferred to it in accordance with section 1841(j) or under paragraph (2).

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the prescription drug rate. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of

estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums paid or deposited (as specified in this subsection) into the Treasury in the year.

"(b) The provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund.

"(c) Notwithstanding any other provision of this title, all payments under this part on or after January 1, 1990, for benefits and administrative costs relating to covered outpatient drugs shall be made from the Trust Fund.

"(d)(1) The Secretary of the Treasury, in consultation with the Board of Trustees of the Trust Fund, shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1992), information on—

"(i) the outlays made from the Trust Fund in the preceding year, and

"(ii) the balance in the Trust Fund as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the prescription drug monthly premiums to be established under section 1839(g) for months in the succeeding year.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1992), respecting the distribution of outlays from the Trust Fund in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

"(e) In this part, with respect to the Trust Fund and the Medicare Catastrophic Coverage Account, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) TRANSFERS OF CERTAIN PREMIUMS.—

(1) TRANSFER OF FLAT PRESCRIPTION DRUG PREMIUMS TO FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND.—Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following new subsection:

"(i) Notwithstanding the previous provisions of this subsection, premiums collected under this part which are attributable to a prescription drug monthly premium established under section 1839(g) shall, instead of being transferred to (or being deposited to the credit of) the Federal Supplemental Medical Insurance Trust Fund, be transferred to (or deposited to the credit of) the Federal Catastrophic Drug Insurance Trust Fund.".

(2) Transfer of supplemental catastrophic coverage premiums into the SMI trust fund.—Section 1841(a) (42 U.S.C. 1395t(a)) is amended by adding the following: "There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the catastrophic coverage rate and which are not otherwise appropriated under section 1817A(a)(2) to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums under section 59B of the Internal Revenue Code of 1986 paid or deposited into the Treasury in the year.".

(c) Conforming Amendments.—

(1)(A) Section 201(g)(1)(A) (42 U.S.C. 401(g)(1)(A)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(B) Section 201(i)(1) (42 U.S.C. 401(i)(1)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Hospital Insurance Catastrophic Coverage Reserve Fund, Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(2) Section 1833(a) (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by inserting "or, as provided in section 1841A(c), from the Federal Catastrophic Drug Insurance Trust Fund" after "Medical Insurance Trust Fund".

(3) Section 1817(b) (42 U.S.C. 1395i(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1841B and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.".

(4) Section 1841(b) (42 U.S.C. 1395t(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those receipts and outlays in the Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1841B.".

SEC. 213. CREATION OF MEDICARE CATASTROPHIC COVERAGE ACCOUNT.

(a) In General.—Part B of title XVIII is amended by inserting after section 1841A, as inserted by section 212, the following new section:

"MEDICARE CATASTROPHIC COVERAGE ACCOUNT

"SEC. 1841B. (a) For purposes of carrying out certain provisions of this title, and section 59B of the Internal Revenue Code of 1986, there is hereby created on the books of the Treasury of the United States an account to be known as the 'Medicare Catastrophic Coverage Account' (in this section referred to as the 'Account'), to be maintained by the Secretary of the Treasury in consultation with the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. No funds shall actually be transferred into or paid out of the Account, but, for other purposes of this part and for purposes of section 59B of the Internal Revenue Code of 1986, amounts credited to the Account shall be considered receipts of the Account and amounts debited to account shall be considered outlays from the Account.

"(b)(1) The Account shall be—

"(A) credited for receipts of the Federal Supplementary Medical Insurance Trust Fund attributable to the portion of supplemental premiums under section 59B of the Internal Revenue Code of 1986, and the premiums under section 1839(g), attributable to the catastrophic coverage premium rate or catastrophic coverage monthly premium,

"(B) credited for receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and

"(C) debited for outlays made under this title that are attributable to the amendments made by the Medicare Catastrophic Coverage Act of 1988 (other than outlays relating to covered outpatient drugs and related administrative costs).

"(2) In addition, the Account shall be—

"(A) credited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any positive average balance maintained in the Account in a calendar quarter, and

"(A) debited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any negative average balance maintained in the Account in a calendar quarter.

"(3) Credits and debits under this subsection shall be made as of the last date of each month based upon receipts and outlays occurring during the month, as estimated by the Secretary and the Secretary of the Treasury.

"(4) The Account shall also identify (and treat separately) those credits and debits in the Account which are also receipts and outlays in the Federal Supplementary Medical Insurance Trust Fund, those receipts which are also receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and those outlays that are also outlays from the Federal Hospital Insurance Trust Fund.

"(c)(1) The Secretary of the Treasury shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1990), information on—

"(i) the outlays made from the Account in the preceding year, and

"(ii) the balance in the Account as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the catastrophic coverage monthly premiums to be established under section 1839(g) for months in the succeeding year.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1990), respecting the distribution of outlays from the Account in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

"(d) The Secretary of the Treasury shall report to Congress in April of each year on the status of the Account created under this section.".

Subtitle C—Miscellaneous Provisions

SEC. 221. VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) FREE-LOOK PERIOD.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)(B), by striking "and (3)" and inserting "through (4)", and

(2) in subsection (c)—

(A) by striking "and" at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting "; and", and

(C) by adding at the end thereof the following:

"(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited).".

(b) REPORTING OF INFORMATION RELATING TO LOSS RATIOS.—Section 1882(b)(1), as amended by subsection (a), is further amended—

(1) in subparagraph (C), by striking "(A) and (B)" and inserting "(A), (B), and (C)",

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively (D) as subparagraph (D), and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) provides that—

"(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

"(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary;".

(c) CONSUMER INFORMATION.—Section 1882(e) is amended—

(1) by inserting "(1)" after "(e)", and

(2) by adding at the end thereof the following:

"(2) The Secretary shall—

"(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

"(i) the actions and practices that are subject to sanctions under subsection (d), and

"(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

"(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

"(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.".

(d) REVISION OF MODEL STANDARDS; TRANSITION.—Section 1882 is further amended—

(1) in the third sentence of subsection (a), by striking "Such certification" and inserting "Subject to subsection (k)(3), such certification";

(2) in subsection (b), by striking "(for so long as" and inserting "(subject to subsection (k)(3), for so long as"; and

(3) by adding at the end thereof the following new subsections:

"(k)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the 'Association') amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the 'amended NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

"(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as 'Federal model standards') for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified

in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (l))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

"(l)(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

"(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

"(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

"(2) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy—

"(A) issued in a State which—

"(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

"(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

"(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

"(3)(A) The date specified in this paragraph is the earlier of—

"(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

"(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

"(B) In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

"(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

"(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

"(A) the improved benefits under this title contained in the Medicare Catastrophic Coverage Act of 1988, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

"(5) In this subsection, the term 'NAIC Model Transition Regulation' refers to the standards contained in the 'Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions' (as adopted by the National Association of Insurance Commissioners in September 1987).

"(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).".

(e) REQUIRED SUBMISSION OF ADVERTISING.—Section 1882(b) is further amended by adding at the end the following new paragraph:

"(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.".

(f) Appointment of Supplemental Health Insurance Panel Members.—Section 1882(b)(2)(A) is amended by striking "appointed by the President" and inserting "appointed by the Secretary".

(g) Effective Dates.—

(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsections (a) and (b) shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act (as added by subsection (c) of this section).

(3) The amendment made by subsection (f) shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act) by not later than 90 days after the date of the enactment of this Act.

SEC. 222. ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.

The Secretary of Health and Human Services shall—

(1) modify contracts under sections 1833(a)(1)(A) and 1876 of the Social Security Act, for portions of contract years occurring after December 31, 1988, to take into account the amendments made by this Act; and

(2) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

The Secretary shall also provide for appropriate modifications of contracts with health maintenance organizations under section 1876(i)(2)(A) of the Social Security Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, for portions of contract years occurring after December 31, 1988, so as to apply to such organizations and contracts the requirements imposed by the amendments made by this Act upon an organization with a risk-sharing contract under section 1876 of the Social Security Act.

SEC. 223. MAILING OF NOTICE OF MEDICARE BENEFITS AND INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.

(a) Distribution of Notices.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"Sec. 1804. The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

"(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

"(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

"(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.".

(b) DISTRIBUTION OF INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.—Section 1842(h)(5) (42 U.S.C. 1395u(h)(5)) is amended—

(1) by inserting "through an annual mailing" after "under this part",

(2) by striking the last sentence,

(3) by inserting "(A)" after "(5)", and

(4) by adding at the end the following new subparagraph:

"(B) The annual notice provided under subparagraph (A) shall include—

"(i) a description of the participation program,

"(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

"(iii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers, and

"(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.".

(c) REVISION OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(1) in subparagraph (A)—

(A) by inserting "prominent" before "reminder", and

(B) by striking "), and" and inserting "and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),";

(2) in subparagraph (B), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(C) shall include (i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory.".

(d) EFFECTIVE DATES.—

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1989.

(2) The amendments made by subsection (b) shall apply to annual notices beginning with 1989.

(3) The amendments made by subsection (c) shall first apply to explanations of benefits provided for items and services furnished on or after January 1, 1989.

SEC. 224. CHANGES IN CIVIL MONEY PENALTIES FOR CERTAIN PRACTICES OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

Section 1876(i)(6)(B)(i) (42 U.S.C. 1395mm(i)(6)(B)(i)) is amended by adding at the end the following: "plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and return to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,".

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

SEC. 301. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR INDIGENT MEDICARE BENEFICIARIES.

(a) Requirement.—

(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) Phasing-In Required Income Standard to 100 Percent of Poverty Level.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended—

(1) by striking "may not exceed a percentage (not more than 100 percent)" and inserting "shall be at least the percent provided under clause (ii) (but not more than 100 percent)",

(2) by inserting "(i)" after "(2)(A)", and

(3) by adding at the end the following new clause:

"(ii) Except as provided in clause (iii), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 85 percent,
"(II) January 1, 1990, is 90 percent,
"(III) January 1, 1991, is 95 percent, and
"(IV) January 1, 1992, is 100 percent.

"(iii) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under clause (ii), with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 80 percent,
"(II) January 1, 1990, is 85 percent,
"(III) January 1, 1991, is 90 percent,
"(IV) January 1, 1992, is 95 percent, and
"(V) January 1, 1993, is 100 percent.".

(c) Resource Standard.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (3)(A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII (including under part B and, if applicable, under section 1818)";

(2) by amending subparagraphs (B) and (C) of paragraph (3) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Subject to paragraph (4), deductibles established under title XVIII (including those described in section 1813, 1833(b), and section 1834(c)(1)).": and

(3) by adding at the end the following new paragraph:

"(4) In a State which provides medical assistance for prescribed drugs under section 1905(a)(12), instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1834(c)(1), the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a)(10)(A)(i).".

(e) CONFORMING AMENDMENTS.—

(1) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1988" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(2) Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)(X), by striking "subject to subsection (m)(3),",

(B) in subsection (a)(10)(E), by striking "subject to subsection (m)(3),";

(C) in subsection (a)(17), by striking "(m)(4), and (m)(5)" and inserting "(m)(3), and (m)(4)", and

(D) in subsection (m), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

(3) The amendment made by paragraph (1) shall take effect on January 1, 1989, and the amendments made by paragraph (2) shall take effect on July 1, 1989.

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures.'.".

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by subsection (d)(3), is further amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for the percent provided under clause (ii) of such paragraph any percent.".

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsections (e) and (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with January 1989, and

(B) items and services furnished on and after January 1, 1989.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 302. COVERAGE AND PAYMENT FOR PREGNANT WOMEN AND INFANTS WITH INCOMES BELOW POVERTY LINE.

(a) PREGNANT WOMEN AND INFANTS UNDER AGE 1.—

(1) REQUIRING COVERAGE.—Section 1902(a)(10) (42 U.S.C. 1396a) is amended—

(A) in subparagraph (A)(i), by striking "or" at the end of subclause (II), by striking the semicolon in subclause (III) and inserting ", or", and by adding at the end the following new subclause:

"(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;";

(B) by amending subclause (IX) of subparagraph (A)(ii) to read as follows:

"(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV);"; and

(C) in clause (VII) in the matter after and below subparagraph (E), by inserting "(A)(i)(IV) or" before "(A)(ii)(IX)".

(2) DESCRIPTION OF INDIVIDUALS REQUIRED TO BE COVERED.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (1)(C)—

(i) by inserting "at the option of the State," after "(C)", and

(ii) by striking "and" after "1983,"; and

(B) in paragraph (2)(A)—

(i) by striking "not more than 185 percent)" and inserting "(not less than the percentage provided under clause (ii) and not more than 185 percent)";

(ii) by inserting "(i)" after "(2)(A)"; and

(iii) by adding at the end the following new clause:

"(ii) Subject to clause (iii), the percentage provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) July 1, 1989, is 75 percent, and

"(II) July 1, 1990, is 100 percent.

"(iii) In the case of a State which, as of the date of the enactment of this clause, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii) shall not be less than—

"(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

"(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii) to exceed 100 percent.".

(b) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS AND ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—

(1) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended, in the matter after and below subparagraph (E)—

(A) by striking "and" before "(IX)", and

(B) by inserting before the semicolon at the end the following: ", and (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to

such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals".

(2) ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—Section 1923(a)(2), as redesignated pursuant to the amendment made by section 411(k)(6)(B) of this Act, is amended by adding at the end the following new subparagraph:

"(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.".

(c) CERTAIN STATE PLAN REQUIREMENTS.—

(1) IN GENERAL.—Subsection (c) of section 1902 (42 U.S.C. 1396a) is amended to read as follows:

"(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if—

"(1) the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

"(2) the State requires individuals described in subsection (l)(1) to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this title.".

(2) ELIMINATING DUPLICATE REQUIREMENT.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by striking paragraph (4).

(3) MAINTENANCE OF EFFORT TO RECEIVE MEDICAL ASSISTANCE FOR OPTIONAL COVERAGE OF PREGNANT WOMEN AND CHILDREN.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (8) and inserting "; or", and

(B) by inserting after paragraph (8) the following new paragraph:

"(9) with respect to any amount of medical assistance for pregnant women and children described in section 1902(a)(10)(A)(ii)(IX), if the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on July 1, 1987.".

(d) TREATMENT OF CERTAIN STATES AND TERRITORIES.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

"(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the

Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

"(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.".

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(e)(6) (42 U.S.C. 1396a(e)(6)) is amended to read as follows:

"(6) At the option of a State, in the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the State plan may nonetheless treat the woman as being an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.".

(2) Section 1902(e)(7) (42 U.S.C. 1396a(e)(7)) is amended—

(A) by striking "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in" and inserting "In",

(B) by inserting "or paragraph (2) of section 1905(n)" after "subsection (l)(1)" the first place it appears, and

(C) by striking "subsection (a)(10)(A)(ii)(IX) and subsection (l)(1)" and inserting "such respective provision".

(3) Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in the matter after and below subparagraph (C) of paragraph (1), by inserting "any of subclauses (I) through (III) of" after "who are not described in", and

(B) in paragraph (3), in the matter before subparagraph (A), by inserting "(a)(10)(A)(i)(IV) or" before "(a)(10)(A)(ii)(IX)".

(4) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended, in the matter before subparagraph (A), by inserting "1902(a)(10)(A)(i)(IV)," before "1902(a)(10)(A)(ii)(IX)".

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) shall take effect on the date of the enactment of this Act.

(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating

funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (b)(2)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 303. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—

(1) Title XIX, as amended by the amendment made by section 411(k)(6)(B) of this Act, is amended—

(A) by redesignating section 1924 as section 1925, and

(B) by inserting after section 1923 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

"SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined to be eligible for medical assistance, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—*In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.*

"(D) REBUTTING OWNERSHIP.—*The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.*

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—*There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse)—*

"(i) *the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and*

"(ii) *a spousal share which is equal to ½ of such total value.*

"(B) ASSESSMENT.—*At the request of an institutionalized spouse or community spouse, at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse has right to a fair hearing under subsection (e)(2)(E) with respect to the determination of the community spouse resource allowance, to provide for an allowance adequate to raise the spouse's income to the minimum monthly maintenance needs allowance.*

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—*In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—*

"(A) *except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and*

"(B) *resources shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed* *under subsection (f)(2)(A) (as of the time of application for benefits).*

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in section 1902(q)(1)), in an amount not less than the amount specified in section 1902(q)(2).

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1902(r)).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

"(i) the applicable percent (described in subparagraph (B)) of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the 'applicable percent' described in this paragraph, effective as of—

"(i) September 30, 1989, is 122 percent,

"(ii) July 1, 1991, is 133 percent, and

"(iii) July 1, 1992, is 150 percent.

"(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

"(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or coopera-

tive, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (C) shall be reduced to the extent the maintenance charge includes utility expenses.

"(5) Court ordered support.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) Notice and Fair Hearing.—

"(1) Notice.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) Fair hearing.—

"(A) In general.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(iii) the computation of the spousal share of resources under subsection (c)(1);

"(iv) the attribution of resources under subsection (c)(2); or

"(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) Revision of minimum monthly maintenance needs allowance.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in

subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as pacticable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan;

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g));

"(iii) the amount established under subsection (e)(2); or

"(iv) the amount transferred under a court order under paragraph (3),

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between

September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(2) Section 1919(c)(1)(B)(i) (42 U.S.C. 1396r(c)(1)(B)(i)) is amended by inserting "and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 1924(c)(1)(B)" before the semicolon.

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(51)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

"(A) 30 months, or

"(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to—

"(i) the spouse of such individual;

"(ii) a child of such individual who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

"(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution or nursing facility; or *"(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date of such individual's admission to the medical institution or nursing facility, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;*

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1924(h)(2), or the individual's child who is blind or permanently and totally disabled;

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who is an inpatient in a medical institution or nursing facility.

"(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) NEW SSI POLICY REGARDING DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE.—

(1) ELIMINATION OF SSI PENALTY; NOTIFICATION OF MEDICAID POLICY LIMITING ELIGIBILITY OF INSTITUTIONALIZED INDIVIDUALS FOR BENEFITS BASED ON SUCH DISPOSAL OF RESOURCES.—Subsection (c) of section 1613 (42 U.S.C. 1382b) is amended to read as follows:

"Notification of Medicaid Policy Restricting Eligibility of Institutionalized Individuals for Benefits Based on Disposal of Resources for Less Than Fair Market Value

"(c)(1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

"(A) inform such individual of the provisions of section 1917(c) providing for a period of ineligibility for benefits under title XIX for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

"(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of

section 1917(c) if such individual (or such spouse, if any) enters a medical institution or nursing facility.

"(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.".

(2) Conforming amendment.—Subparagraph (B) of section 1611(e)(1) (42 U.S.C. 1382(e)(1)) is amended by adding after and below clause (iii) the following new sentence:

"For purposes of this subsection, a hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c) shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1917(c).".

(d) Disregarding Payments for Certain Medical Expenses by Institutionalized Individuals.—Section 1902 (42 U.S.C. 1396), as amended by the amendment made by section 411(n)(3) of this Act, is amended by adding at the end the following new subsection:

"(r) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.".

(e) Conforming Amendment.—Section 1902 (42 U.S.C. 1396a), as amended by the amendment made by section 411(n)(3) of this Act, is amended—

(1) in subsection (a)(10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of subsection (a)(49);

(3) by striking the period at the end of the subsection (a)(50) and inserting "; and";

(4) by inserting after paragraph (50) of subsection (a) the following new paragraph:

"(51)(A) meet the requirements of section 1924 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets)."; and

(5) in subsection (r), as added by subsection (d)—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(B) by inserting "(1)" after "(r)", and

(C) by adding at the end the following new paragraph:

"(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or

under subsection (f) may be less restrictive, and shall be no more restrictive, than the methodology—

"(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

"(ii) in the case of other groups, under the State plan most closely categorically related.

"(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(f) Treatment of Homestead Exemption in Missouri.—The State medical assistance plan of Missouri shall not be in compliance with the requirements of title XIX of the Social Security Act as of October 1, 1989, unless such plan is amended to provide that, in determining the resources of any aged, blind, or disabled individual in the State who applies for medical assistance under such plan on or after such date, the State will not consider the home of the individual as a resource, regardless of the value of the home.

(g) Effective Date.—

(1)(A) The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1924 of the Social Security Act (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of such date to individuals institutionalized on or after such date.

(2)(A) The amendment made by subsection (b) and section 1902(a)(51)(B) of the Social Security Act, apply (except as provided in paragraph (5)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, or the date of the enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1917(c) of the Social Security Act, as amended by subsection (b) of this section, shall apply to resources disposed of on or after July 1, 1988.

(C) Notwithstanding subparagraphs (A) and (B), a State may continue to apply the policies contained in the State plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988.

(3) The amendments made by subsection (c) shall apply to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(4) The amendment made by subsection (d) is effective on and after April 8, 1988. The final rule of the Health Care Financing

Administration published on February 8, 1988 (53 Federal Register 3586) is superseded to the extent inconsistent with the amendment made by subsection (d).

(5) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (e)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(6) The amendments made by paragraphs (1) and (5) of subsection (e) shall apply to medical assistance furnished on or after October 1, 1982.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

SEC. 401. ESTABLISHMENT.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this title referred to as the "Commission").

SEC. 402. DUTIES.

(a) In General.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—*In making its recommendations, the Commission shall consider—*

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—*In this title:*

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

SEC. 403. MEMBERSHIP.

(a) APPOINTMENT.—*The Commission shall be composed of 15 members appointed as follows:*

(1) The President shall appoint 3 members.

(2) The President Pro Tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members of the Senate, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same political party.

(b) CHAIRMAN AND VICE CHAIRMAN.—*The Commission shall elect a chairman and vice chairman from among its members.*

(c) VACANCIES.—*Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.*

(d) QUORUM.—*A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 405(a).*

(e) MEETINGS.—*The Commission shall meet at the call of its chairman or a majority of its members.*

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—*Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.*

SEC. 404. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

SEC. 405. POWERS.

(a) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under paragraph (1).

(d) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(e) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(h) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to

the Commission on a reimbursable basis such administrative support services as the Commission may request.

(i) Acceptance of Donations.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 406. REPORT.

(a) Report on Comprehensive Long-Term Care Services for the Elderly and Disabled.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) Report on Comprehensive Health Care Services.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 407. TERMINATION.

The Commission shall terminate 30 days after the date of submission of the report required in section 406(b).

SEC. 408. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

Subtitle B—OBRA Technical Corrections

SEC. 411. TECHNICAL CORRECTIONS TO CERTAIN HEALTH CARE PROVISIONS IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.

(a) Reference to OBRA and Effective Dates.—

(1) Reference.—In this section, the term "OBRA" refers to the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203).

(2) Effective date.—Except as specifically provided in this section, the amendments made by this section, as they relate to a provision in OBRA, shall be effective as if they were included in the enactment of that provision in OBRA.

(3) Ratification of enrollment corrections and printed enrollment.—

(A) In general.— Except as provided in subparagraph (B), the enrollment corrections noted in footnotes numbered 9 through 72 of OBRA are hereby ratified and shall be considered to have been enacted as part of OBRA. The printed enrollment of title IV of OBRA, as prepared and printed under section 8004 of OBRA (including the footnote corrections described in subparagraph (B) and as incorporating the clarifications described in subparagraph (C)), shall be deemed to constitute title IV of OBRA as enacted.

(B) Footnote corrections.—(i) With respect to the reference to which footnote 28 relates (101 Stat. 1330-81), the reference shall be deemed to have read "1320a–7b)".

(ii) With respect to the word to which footnote 30 relates (101 Stat. 1330-91), the word shall be deemed to have read "the".

(iii) With respect to the designation to which footnote 52 relates (101 Stat. 1330-151), the designation shall be deemed to have read "(F)".

(C) Clarifications of illegible matter.—(i) Section 1842(n)(1)(A) of the Social Security Act, as added by section 4051(a) of OBRA (101 Stat. 1330-93), is deemed to have the phrase "the supplier's reasonable charge to individuals enrolled under this part for the test" immediately after "or, if lower, the".

(ii) Section 1834(a)(7)(B)(i) of the Social Security Act, as inserted by section 4062(b) of OBRA (101 Stat. 1330-103), is deemed to have a reference to "1987" immediately after "December".

(b) Corrections Relating to Part 1 of Subtitle A of Title IV (Part A of the Medicare Program).—

(1) Section 4002.—(A) Subclauses (III) and (IV) of section 1886(b)(3)(B)(i) of the Social Security Act, as amended by section 4002(a) of OBRA, are amended by striking "other hospitals" and inserting "for hospitals located in other urban areas".

(B) Section 1886(b)(3)(B)(i)(IV) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by striking "percent" each place it appears and inserting "percentage points".

(C) Section 1886(b)(3)(B)(i)(V) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by inserting "increase" after "market basket percentage".

(D) The second sentence of section 1886(d)(2)(D) of the Social Security Act, as amended by section 4002(b) of OBRA, is amended by striking "the publication described in subsection (e)(5)(B)" and inserting "the publications described in subsection (e)(5)".

(E) Section 4002(c)(1)(B)(iii) of OBRA is amended, in the matter stricken, by striking the comma after "available".

(F) Section 1886(d)(3)(A)(ii) of the Social Security Act, as amended by section 4002(c)(1)(C) of OBRA, is amended by striking "in urban areas" and inserting "in other urban areas".

(G) Section 1886(d)(1)(A)(iii) of the Social Security Act, as amended by section 4002(d) of OBRA, is amended by striking "if greater" and inserting "if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area".

(H)(i) Section 1886(d)(2)(D) of the Social Security Act is amended by striking the last sentence (added by section 4002(f)(1)(A) of OBRA).

(ii) Section 4002(f) of OBRA is amended by adding at the end the following new paragraph:

"(3) The second sentence of section 1813(b)(1) of the Social Security Act (42 U.S.C. 1395e(b)(1)) is amended by striking 'applicable percentage increase' and all that follows through 'is applied' and inserting 'Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B)) which are applied'.".

(iii) The amendment made by clause (ii) shall apply to the inpatient hospital deductible for years beginning with 1989.

(I) Section 4002(g) of OBRA is amended—

(i) in paragraph (1)(A), by striking "1886(a)(1)(A)(iii)" and inserting "1886(d)(1)(A)(iii)",

(ii) in paragraphs (1)(B) and (2)(B), by striking "1886(d)(3)(B)" and inserting "1886(b)(3)(B)", and

(iii) in paragraph (6), by striking "1886(d)(10)(B)" and inserting "1886(d)(1)(B)".

(2) SECTION 4003.—Section 4003(d) of OBRA is amended—

(A) in paragraph (2)—

(i) by inserting "(other than under section 1886(d)(5)(F) of such Act)" after "receives payments", and

(ii) by inserting "of such services" after "reasonable costs"; and

(B) in the matter following paragraph (2), by inserting "the" after "facilities of".

(3) SECTION 4004.—Section 4004(a) of OBRA is amended by inserting "(1)" after "SURVEY.—" and by adding at the end the following new paragraph:

"(2) Section 1886(d)(9)(C)(iv) of such Act is amended by adding at the end the following new sentence: 'The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.'".

(4) SECTION 4005.—(A) Section 1886(d)(8)(B) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended—

(i) by striking "The Secretary" and inserting "For purposes of this subsection, the Secretary", and

(ii) by striking all that follows "if" and inserting the following: "the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).".

(B) Section 1886(d)(8)(C) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended by striking "standardized amount" and inserting "standardized amounts".

(C) Section 4005(a) of OBRA is amended—

(i) in paragraph (1)(D), by striking "subparagraph" and inserting "subparagraphs", and

(ii) in paragraph (3), by striking "This section, and the amendments made by paragraph (1)," and inserting "This subsection".

(D) Section 1883(d)(3) of the Social Security Act, as added by section 4005(b)(2)(B) of OBRA, is amended by inserting before the period at the end the following: ", except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph".

(5) SECTION 4006.—(A) Section 1886(g)(3)(A)(iv) of the Social Security Act, as amended by section 4006(a) of OBRA, is amended by inserting "for payments attributable" after "15 percent".

(B) Section 4006(a) of OBRA is amended—

(i) by adding "and" at the end of subparagraph (A), and

(ii) by redesignating (A) and (B) as paragraphs (1) and (2), respectively.

(6) SECTION 4007.—Section 4007 of OBRA is amended—

(A) in the second sentence of subsection (a), by striking "updata" and inserting "updated";

(B) by amending subsection (b) to read as follows:

"(b) REQUIRING REPORTING OF STANDARDIZED COST REPORT ELECTRONICALLY.—

"(1) IN GENERAL.—Section 1886(f)(1) of the Social Security Act (42 U.S.C. 1395ww(f)(1)) is amended—

"(A) by striking ', for a period ending not earlier than September 30, 1988,',

"(B) by inserting '(A)' after '(f)(1)', and

"(C) by adding at the end the following new subparagraph:

" '(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

" '(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).'.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(C) shall apply to hospital cost reporting periods beginning on or after October 1, 1989."; and

(C) in subsection (c)—

(i) in paragraph (1)—

(I) by striking "3-year", and

(II) by striking "contracting" and inserting "conducting";

(ii) in paragraph (2), by striking "by category of service and" in subparagraphs (A) and (B);

(iii) in paragraph (2)(C), by striking "(by category of service)";

(iv) in paragraph (2), by striking subparagraph (D) and redesignating subparagraphs (E) through (L) as subparagraphs (D) through (K), respectively;

(v) by amending subparagraph (I), as so redesignated, to read as follows:

"(I) Bad debt and charity care.";

(vi) in paragraph (2), by adding at the end the following:

"The Secretary shall develop a definition of 'outpatient visit' for purposes of reporting hospital information.";

(vii) in paragraph (5), by striking "paragraph (3)" and inserting "paragraph (2)";

(viii) in paragraph (5)(A), by striking "The terms" and all that follows through "as" and inserting "The term 'bad debt and charity care' has such meaning as";

(ix) in paragraph (5)(B)—

(I) by inserting "at least" after "to payors",

(II) by striking "title VIII" and inserting "title XVIII", and

(III) by striking "self-paying individuals" and inserting "and other persons (including self-paying individuals)"; and

(x) in paragraph (6)—

(I) by striking "$1,000,000 for each of" and inserting "a total of $3,000,000 for",

(II) by inserting "or from operation funds" after "research funds",

(III) by striking ", and at least" and all that follows through "operations funds" and inserting "and", and

(IV) by striking "over 3 years".

(7) SECTION 4008.—Section 4008(d)(1)(B) of OBRA is amended by striking "1886" and inserting "1886(d)".

(8) SECTION 4009.—(A) Section 4009(a) of OBRA is amended—

(i) by striking paragraphs (1) and (2) and inserting the following:

"(1) INCREASE IN CIVIL MONETARY PENALTY AND EXCLUSION OF RESPONSIBLE PHYSICIAN VIOLATORS.—Section 1867(d)(2) of the Social Security Act (42 U.S.C. 1395dd(d)(2)) is amended—

"(A) in the second sentence—

"(i) by redesignating such sentence as subparagraph (C),

"(ii) by striking 'previous sentence' and inserting 'this paragraph', and

"(iii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

"(B) by striking the first sentence and inserting the following: '(A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under

this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

" '(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1842(j)(2), except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.' "; and

(ii) by redesignating paragraph (3) as paragraph (2).

(B) Section 4009(d)(1)(A) of OBRA is amended, in the matter inserted by such section, by striking the comma after "representatives".

(C) Section 4009(i) of OBRA is amended by striking "New England county metropolitan areas" and "4001(b)" and inserting "urban areas in New England" and "4002(b)", respectively.

(D) Section 4009(j) of OBRA is amended by adding at the end the following new paragraphs:

"(9) Section 1818(c) of the Social Security Act (42 U.S.C. 1395i-2(c)) is amended by striking paragraph (4) and redesignating paragraphs (5) through (7) as paragraphs (4) through (6), respectively.

"(10) Section 9305(d) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking '2 years after the date of the enactment of this Act' and inserting 'January 1, 1990'.".

(c) Corrections Relating to Subpart A of Part 2 of Subtitle A of Title IV (Health Maintenance Organization Reforms).—

(1) Section 4011.—Subparagraph (F) of section 1876(c)(3) of the Social Security Act, as added by the amendment made by section 4011(a)(1) of OBRA, is amended by moving its indentation 4 ems to the left so its left margin is aligned with the left margin of subparagraph (G) of that section, as added by section 4011(b)(1) of OBRA.

(2) Section 4012.—(A)(i) Section 1866(a)(1)(O) of the Social Security Act, as inserted by section 4012(a) of OBRA, is amended by striking "with a risk-sharing contract under section 1876" and inserting "(i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization".

(ii) The amendment made by clause (i) shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act.

(B) Section 4012(c) of OBRA is amended by striking "paragraph (2)" and inserting "subsection (a)".

(3) Section 4013.—Section 4013 of OBRA is amended by striking "(a) In General" and all that follows through the end and inserting the following:

"Section 2350(b)(3) of the Deficit Reduction Act of 1984 is amended by striking 'four years after the date of the enactment of this Act' and inserting 'September 30, 1990'.".

(4) SECTION 4014.—Section 1876(i)(6) of the Social Security Act, as amended by section 4014 of OBRA, is amended—

(A) in subparagraph (A), by inserting ", in addition to any other remedies authorized by law," after "the Secretary may provide", and

(B) in the last sentence of subparagraph (B), by striking "under that section" and inserting "or proceeding under section 1128A(a)".

(5) SECTION 4018.—Section 1876(f)(3)(A) of the Social Security Act, as inserted by section 4018(a) of OBRA, is amended—

(A) by inserting "enrollment and residency requirements under this section and for" after "for purposes of", and

(B) by striking "of the subdivision" and inserting "described in subparagraph (B)(iii) who receive services through the subdivision".

(d) CORRECTIONS RELATING TO SUBPART B OF PART 2 OF SUBTITLE A OF TITLE IV (HOME HEALTH QUALITY).—

(1) SECTION 4021.—(A) Section 1891(a) of the Social Security Act, as added by section 4021(b) of OBRA, is amended—

(i) in paragraph (3)(A), by striking "who is not a licensed health care professional (as defined in subparagraph (F))",

(ii) in paragraph (3)(F), by inserting "physical or occupational therapy assistant," after "occupational therapist,", and

(iii) by striking paragraph (4) and by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively.

(B)(i) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by inserting before the period at the end the following: "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment".

(ii) The amendment made by clause (i) shall apply to equipment furnished on or after the effective date provided in section 4021(c) of OBRA.

(2) SECTION 4022.—(A) The third sentence of section 1891(c)(1) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by inserting "(other than subsections (a) and (b))" after "1128A".

(B) Section 1891(d)(2)(A) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by striking "1991" and inserting "1992".

(3) SECTION 4023.—(A) Section 4023 of OBRA is amended by inserting "(a) IN GENERAL.—" before "Section 1891".

(B) Section 1891(f)(2)(A) of the Social Security Act, as added by section 4023 of OBRA, is amended—

(i) by moving the indentation of clauses (i) through (iii) (and the sentence following clause (iii)) 2 ems to the left,

(ii) in clause (i), by striking "for each day of noncompliance" and inserting "in an amount not to exceed $10,000 for each day of noncompliance", and

(iii) by inserting after and below clause (iii), the following:

"The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(C) Section 4023(b) of OBRA is amended by inserting before the period at the end the following: ", and no intermediate sanction described in section 1891(f)(2)(A) of such Act shall be imposed for violations occurring before such effective date".

(4) SECTION 4025.—(A) Section 1864(a) of the Social Security Act is amended—

(i) in the first sentence added by section 4025(a) of OBRA, by striking "most recent accreditation survey conducted with respect to the agency," and inserting "most recent accreditation survey conducted by a State agency or private accreditation agency under section 1865 with respect to the home health agency,", and

(ii) in the second sentence so added—

(I) by inserting "such State or local" before "agency" the first place it appears, and

(II) by striking "section 1864" and inserting "section 1865".

(B) Section 4025 of OBRA is amended—

(i) in subsection (b), by striking "subsection (a)" and inserting "this section" and by redesignating such subsection as subsection (c), and

(ii) by inserting after subsection (a) the following new subsection:

"(b) CONFORMING AMENDMENT.—The last sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting '(other than a survey with respect to a home health agency' after 'any accreditation survey'.".

(5) SECTION 4026.—(A) Section 1861(v)(1)(L)(iii) of the Social Security Act, as added by section 4026(a)(1) of OBRA, is amended—

(i) by striking "audited" each place it appears and inserting "verified", and

(ii) by adding at the end the following:

"In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this title until such date as the Secretary determines that such data has been satisfactorily provided.".

(B) Section 4026(a)(2) of OBRA is amended by striking "July 1, 1988" and inserting "July 1, 1989".

(C) Section 4026(b) of OBRA is amended by striking "June 1, 1988" and inserting "June 1, 1989".

(6) SECTION 4027.—Section 4027(a) of OBRA is amended by striking "July 1, 1988" and inserting "April 1, 1989".

(e) CORRECTIONS RELATING TO SUBPART C OF PART 2 OF SUBTITLE A OF TITLE IV (OTHER MEDICARE PART A AND B PROVISIONS).—

(1) SECTION 4032.—(A) Section 4032 of OBRA is amended by striking "AND PHYSICIAN REVIEW" in the heading of subsection (a) and by striking "AND CARRIERS" in the heading of subsection (b).

(B) Section 1816(j)(2) of the Social Security Act, as added by section 4032(a) of OBRA, is amended—

(i) by inserting "in the case of a request for reconsideration of a denial," after "(2)", and

(ii) by inserting "the" before "disposition".

(C) Section 4032(c)(1)(B) of OBRA is amended by striking "claims filed" and inserting "reconsiderations requested".

(2) SECTION 4033.—Section 4033 of OBRA is amended—

(A) by striking "(a) IN GENERAL.—";

(B) by redesignating paragraphs (1) and (2) (and subparagraphs (A) and (B) of paragraph (2)) as subsections (a) and (b) (and paragraphs (1) and (2) of subsection (b)), respectively; and

(C) by aligning the left margins of the matter in such section flush left.

(3) SECTION 4039.—Section 4039 of OBRA is amended by adding at the end the following new subsection:

"(h) TECHNICAL CORRECTIONS.—

"(1) Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a-7a(b)) is amended—

"(A) in paragraph (1)(A), by striking 'XVII' and inserting 'XVIII', and

"(B) in paragraph (2) by inserting 'each' after '$2,000 for'.

"(2) Section 1138(a)(1)(B) of such Act (42 U.S.C. 1320b-8(a)(1)(B)) is amended by striking 'In' and inserting 'in'.

"(3) Section 1154(a)(4) of such Act (42 U.S.C. 1320c-3(a)(4)) is amended—

"(A) by indenting subparagraphs (B) and (C) (and clauses (i) through (iii) of subparagraph (C)) two additional ems;

"(B) in subparagraph (B), by inserting 'risk-sharing' before 'contract under section 1876'; and

"(C) in subparagraph (C)(i), by adding before the comma at the end the following: '(other than the ability to perform review functions under this section that are not described in subparagraph (B))'.

"(4) Section 1154(d) of such Act (42 U.S.C. 1320c-3(d)) is amended by striking '1164(b)(4)' and inserting '1164'.

"(5) Section 1156(b) of such Act (42 U.S.C. 1320c-5(b)) is amended—

"(A) in the second sentence of paragraph (1), by striking 'such services on a reimbursable basis.' and inserting 'services under this Act on a reimbursable basis.', and

"(B) in paragraph (2), by striking 'at such time' and all that follows through 'and shall remain' and inserting 'on the same date and in the same manner as an exclusion from participation under the programs under this Act becomes effective under section 1128(c), and shall remain'.

"(6) Section 1160 of such Act (42 U.S.C. 1320c-9) is amended by adding at the end the following new subsection:

" '(e) For purposes of this section and section 1157, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1154(a)(4)(C).'.

"(7) The heading of section 1870 of such Act (42 U.S.C. 1395gg) is amended to read as follows:

'OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS'.

"(8) Section 1876(i)(7) of such Act (42 U.S.C. 1395mm(i)(7)) is amended—

"(A) in subparagraph (A), by striking 'Except as provided under section 1154(a)(4)(C), each' and inserting 'Each';

"(B) in subparagraph (A), by inserting 'or with an entity selected by the Secretary under section 1154(a)(4)(C)' after 'located)'; and

"(C) by striking 'peer' in subparagraph (B) and the second place it appears in subparagraph (A).

"(9) Section 9353 of the Omnibus Budget Reconciliation Act of 1986 is amended—

"(A) in subsection (a)(6)(A)(i), by striking 'paragraphs (1) and (2)(D) shall apply to contracts as of' and inserting 'paragraph (1) shall apply to contracts entered into or renewed on or after';

"(B) in subsection (a)(6)(B), by striking 'amendment made by paragraph (2)(B)' and inserting 'amendments made by paragraphs (2)(B) and (2)(D)'; and

"(C) in subsection (e)(3)(B), by adding at the end the following: 'The provisions of section 1876(i)(7) of the Social Security Act (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97-248) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act).'.".

(f) CORRECTIONS RELATING TO SUBPART A OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR PHYSICIANS' SERVICES).—

(1) SECTION 4041.—(A) Section 4041(a)(1)(B) of OBRA is amended—

(i) by inserting "as amended retroactively by section 4085(i)(7)(C)," after "(j)(1)(C),", and

(ii) by redesignating the clause added by such section as clause (viii).

(B) The last sentence of section 1842(b)(2) of the Social Security Act, as added by section 4041(a)(3)(A) of OBRA, is amended by striking "and subsection (h)" and inserting ", subsection (h), and section 1845(f)(2)".

(C) Subclause (II) of section 4041(a)(3)(B)(iii) of OBRA is amended to read as follows:

"(II) by striking 'April 1' and inserting 'September 30', and".

(2) SECTION 4042.—(A) Section 1842(b)(4)(F)(iii) of the Social Security Act, as added by section 4042(a) of OBRA, is amended—

(i) in subclause (I), by striking the semicolon and inserting a comma, and

(ii) in subclause (II), by striking "physician's" and inserting "physicians' ".

(B) Section 1842(b)(4)(F)(ii)(I) of the Social Security Act, as added by section 4042(a) of OBRA, is amended by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)".

(C) Section 4042(b) of OBRA is amended by striking "Section" and all that follows up to "The term" and inserting the following:

"(1) Section 1842 of such Act (42 U.S.C. 1395u) is amended—

"(A) in subsection (h)(7), by striking ', described in paragraph (8)';

"(B) in paragraph (8) of subsection (h)—

"(i) by striking '(8) For purposes of this title, a' and inserting '(1) A',

"(ii) by indenting such paragraph 2 ems, and

"(iii) by inserting before such paragraph the following:

" '(i) For purposes of this title:';

"(C) in subsection (b)(4)(E)—

"(i) by striking '(E) In this section:',

"(ii) by redesignating clauses (i) and (ii), as paragraphs (2) and (3), respectively, and

"(iii) by transferring and inserting such paragraphs, as redesignated, before subsection (j);

"(D) in subsection (b)(4), by redesignating subparagraphs (F) and (G) of subsection (b)(4), as subparagraphs (E) and (F), respectively; and

"(E) by inserting, after the paragraphs transferred and inserted by subparagraph (C)(iii) the following, new paragraph:

" '(4)".

(D) Section 4042(b) of OBRA is further amended by adding at the end the following:

"(2)(A) Section 1842(b)(4)(A)(vii) of such Act, as redesignated by sections 4041(a)(1)(A)(i) and 4044(a) is amended by striking 'subparagraph (E)(ii)' and inserting 'subsection (i)(3)'.

"(B) Section 1833(l)(2) of such Act (42 U.S.C. 1395l(l)(2)) is amended by striking '1842(b)(4)(E)(ii)' and inserting '1842(i)(3)'.".

(E) The last sentence of section 1842(b)(4)(A)(iv)(II) of the Social Security Act, as added by section 4042(c)(2) of OBRA, is amended by striking "January 1, 1988" and inserting "January 1, 1989".

(F) Section 4042(c) of OBRA is amended—

(i) by striking "Section" and all that follows up to "In the previous sentence" and inserting the following:

"(1) The first sentence of clause (iv) of section 1842(b)(4)(A) of such Act (42 U.S.C. 139u(b)(4)(A)) is amended to read as follows: 'The reasonable charge for physicians' services furnished on or after January 1, 1987, by a nonparticipating physician shall be

no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level).'.", and

(ii) by adding at the end the following:

"(2) Subclauses (I) and (II) of section 1842(j)(1)(C)(i) of such Act are amended by striking 'prevailing charge for the year involved for such service furnished by nonparticipating physicians' and inserting 'applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved'.".

(3) SECTION 4044.—(A) Section 4044(a) of OBRA is amended by striking "INCREASE IN PREVAILING CHARGES" and inserting "PREVAILING CHARGE FLOOR".

(B) Section 1842(b)(4)(A)(vi) of the Social Security Act, as inserted by section 4044(a) of OBRA, is amended—

(i) by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)",

(ii) by striking "the average of the prevailing charge levels" and inserting "the estimated average prevailing charge levels based on the best available data", and

(iii) by striking "for participating physicians".

(4) SECTION 4045.—(A) Section 1842(b)(10) of the Social Security Act, as amended by section 4045(a) of OBRA, is amended—

(i) in subparagraph (A)(i)—

(I) by striking "under paragraph (3)",

(II) by striking "subparagraph (C)" and inserting "subparagraph (B)", and

(III) by striking "for participating and nonparticipating physicians";

(ii) in subparagraph (A)(iii), by striking "clause (i)(II)" and inserting "clause (i)(I)";

(iii) in subparagraph (B) by inserting "(including subsequent insertion of an intraocular lens)" after "cataract surgery"; and

(iv) in subparagraph (D), by inserting "under" after "review".

(B) Section 4045(c)(2) of OBRA is amended—

(i) in subparagraph (B), by inserting before the period at the end the following: "and by striking the second sentence", and

(ii) by adding at the end the following new subparagraph:

"(D) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting '(or under any other provision of law affecting the prevailing charge level)' after 'the level determined under this sentence'.".

(C) Section 1842(j)(1)(D)(iv) of the Social Security Act, as added by section 4045(c)(1)(B) of OBRA, is amended by striking "imposes a charge" and inserting "bills".

(D)(i) Section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)) is amended by inserting "(including subsequent insertion of an intraocular lens)" after "operation".

(ii) The amendment made by clause (i) shall apply to operations performed on or after 60 days after the date of the enactment of this Act.

(5) SECTION 4046.—(A) Section 1842(b)(11)(C)(i) of the Social Security Act, as inserted by section 4046(a)(1)(C) of OBRA and as designated by section 4063(a)(1)(A), is amended by striking "implantation" and inserting "insertion".

(B) Section 1842(j)(1)(D)(ii)(IV) of the Social Security Act, as inserted by section 4046(a)(2)(A) of OBRA, is amended by striking "is".

*(6) SECTION 4047.—(A) The heading of section 4047 of OBRA is amended by striking "**PRIMARY CARE**" and inserting "**CERTAIN**".*

(B) Section 1842(b)(4)(G) of the Social Security Act, as added by section 4047(a) of OBRA, is amended—

(i) by inserting "than" after "(other", and

(ii) by striking "(as determined under the third and fourth sentences of paragraph (3) and under paragraph (4))".

(C) Section 4047(b) of OBRA is amended by inserting "on or" after "medicare beneficiaries".

(D) The item in the table of contents of title IV of OBRA relating to section 4047 is amended to read as follows:

"Sec. 4047. Customary charges for certain services of new physicians.".

(7) SECTION 4048.—(A) Paragraph (14) of section 1842(b) of the Social Security Act, as added by section 4048(a) of OBRA, is redesignated as paragraph (13).

(B) Section 4048 of OBRA is amended by adding at the end the following new subsection:

"(e) CONFORMING AMENDMENT TO MAXMIMUM ALLOWABLE ACTUAL CHARGE.—Section 1842(j)(1)(C) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)), as amended by sections 4085(i)(7)(C) and 4041(a)(1)(B) of this title, is amended by adding at the end the following new clause:

" '(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.'.".

(8) SECTION 4049.—(A) Section 1834(b)(6) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended by striking "radiologic" each place it appears and inserting "radiology".

(B) Section 4049(a) of OBRA is amended—

(i) in paragraph (1), by striking "4062(c)(3)" and inserting "4062(d)(3)", and

(ii) in paragraph (2), by striking "4062(a)" and inserting "4062(b)".

(C) Section 1833(a)(1) of the Social Security Act, as amended by section 4049(a)(1) of OBRA, is amended in the clause added by that section by striking "1834(b)(5)" and inserting "1834(b)(6)".

(D) Section 1834(b) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended—

(i) in the headings of paragraphs (4)(D) and (5), by inserting "AND SUPPLIERS" after "PHYSICIANS";

(ii) in paragraph (5)(C), by striking "imposes a charge" and inserting "bills";

(iii) in paragraph (5)(C), by inserting "in the same manner as such sanctions may apply to a physician" after "1842(j)(2)";

(iv) in paragraph (6), by striking ", section 1833(a)(1)(I), and section 1842(h)(1)(B)" and inserting "and section 1833(a)(1)(J)"; and

(v) in paragraph (6)(B), by striking "billings" and inserting "the total amount of charges".

(E) Section 4049(b) of OBRA is amended by striking "establish" and inserting "propose".

(9) SECTION 4051.—Section 1842(n) of the Social Security Act, as added by section 4051(a) of OBRA, is amended—

(A) in paragraph (1) in the matter before subparagraph (A)—

(i) by striking "to a patient",

(ii) by inserting "the bill or request for" after "for which",

(iii) by striking "his" and inserting "a", and

(iv) by striking "supervised the test" and inserting "supervised the performance of the test";

(B) in paragraph (1)(A), by striking "to individuals enrolled under this part";

(C) in paragraph (2)(A), by inserting "the payment amount specified in paragraph (1)(A) and" after "other than"; and

(D) in paragraph (3), by striking "or supplier".

(10) FIRST SECTION 4052.—(A) Section 1892(a) of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(i) in paragraphs (2)(C)(ii) and (3)(B), by striking "paragraph (3)" and inserting "paragraph (4)",

(ii) in paragraph (4), by striking "bar" and inserting "exclude", and

(iii) in paragraph (4), by inserting before the period at the end the following: "if a State requests that the physician not be excluded".

(B) The first section 4052(b) of OBRA (relating to conforming reference) is amended by striking "338E(b)(1)" and "254o(b)(1)" and inserting "338E(b)(1)(B)(i)" and "254o(b)(1)(B)(i)", respectively.

(C)(i) Section 1892 of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(I) in the heading, by striking "PHYSICIANS" and "SCHOLARSHIP" and inserting "INDIVIDUALS" and "SCHOLARSHIP AND LOAN", respectively;

(II) by striking "physician" each place it appears (other than the third place it appears in subsection (a)(4)) and inserting "individual";

(III) by striking "physician" the third place it appears in subsection (a)(4) and inserting "practitioner";

(IV) in paragraph (1)(A), by inserting ", the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program," after "Scholarship Program";

(V) in subsection (b), by striking ", and (2)" and all that follows through "Act" and inserting "or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section"; and

(VI) in subsection (b), by striking the period at the end and inserting "; or" and by adding at the end the following:

"(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.".

(ii) Section 733(f) of the Public Health Service Act (42 U.S.C. 294f(f)) is amended by adding at the end the following: "Procedures for reduction of payments under the medicare program are provided under section 1892 of the Social Security Act.".

(iii) The amendments made by this subparagraph shall be effective 30 days after the date of the enactment of this Act.

(11) SECOND SECTION 4052.—(A) The second section 4052(a) of OBRA is amended by striking "is amended" and all that follows through the end and inserting the following: "is amended by inserting before the period at the end of the next-to-last sentence the following: ', and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level'.".

(B) The second section 4052(b) of OBRA is amended by striking "January" and inserting "April".

(12) SECTION 4054.—(A) Section 4054 of OBRA is amended to read as follows:

"SEC. 4054. APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES.

"(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

"(1) in subsection (a)(1), by striking clause (F),

"(2) in subsection (b), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively, and

"(3) in subsection (i), by striking paragraph (4).

"(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after April 1, 1988.".

(B) The item relating to section 4054 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4054. Applying copayment and deductible to certain outpatient physicians' services.".

(13) SECTION 4055.—Section 4055 of OBRA is amended—

(A) in subsection (a)(2), by striking "such list" and inserting "such definitions", and

(B) in subsection (b)(1), by striking "dermatology,".

(14) Redesignation.—The second section 4052 of OBRA and sections 4053, 4054, and 4055 of OBRA are redesignated as sections 4053 through 4056, respectively.

(g) Corrections Relating to Subpart B of Part 3 of Subtitle A of Title IV (Payments for Other Part B Services).—

(1) Section 4062.—(A) The heading of section 1834 of the Social Security Act, as inserted by section 4062(b) of OBRA, is amended by inserting "ITEMS AND" after "PARTICULAR".

(B) Subsection (a) of section 1834 of the Social Security Act, as so inserted, is amended—

(i) in paragraph (1)(C), by inserting "or under part A to a home health agency" after "under this part";

(ii) in the second sentence of paragraph (2)(A), by striking "rental" before "payments";

(iii) in paragraph (2)(B)(i), by striking "allowed" and inserting "reasonable", and in paragraphs (3)(B)(i) and (8)(A)(i)(I), by striking "allowable" and inserting "reasonable";

(iv) in paragraph (3)(A), by striking the extra space after "ventilators";

(v) in paragraph (4), by inserting after "individual patient" the following: ", and for that reason cannot be grouped with similar items for purposes of payment under this title,";

(vi) in paragraph (4), by inserting "(A)" after "in a lump-sum amount" and by inserting "(B)" after "for that item, and";

(vii) in paragraph (4), by striking "maintenance and service" each place it appears and inserting "maintenance and servicing", in paragraph (7)(A)(iii), by striking "service and maintenance" and inserting "maintenance and servicing", and in paragraphs (7)(A)(ii) and (11)(A), by striking "servicing" and inserting "maintenance and servicing";

(viii) in paragraph (7)(A)(iii)(I), by striking "fee established by the carrier" and inserting "fee or fees established by the Secretary ";

(ix) in paragraph (9)(A)(ii)(I), by striking "12-month period" and inserting "6-month period";

(x) in paragraph (9)(A)(ii)(II), by striking "and to 1991" and inserting ", 1991, and 1992";

(xi) in paragraphs (9)(B)(i) and (10)(B)(i), by striking the comma after "1991";

(xii) in paragraph (9)(C)(i), by striking "subparagraph (A)(ii)(I)" and inserting "subparagraph (A)(ii)";

(xiii) in paragraph (10)(B), by inserting before the period the following: "and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1842(b)";

(xiv) in the last sentence of paragraph (11)(A), by striking "under subsection (j)(2)" and inserting "under section 1842(j)(2)";

(xv) in paragraph (12), by striking "(as defined in section 1886(d)(2)(D))"; and

(xvi) by striking paragraph (14).

(C) Section 4062(c)(4) of OBRA is amended—

(i) by inserting "and payment of a reasonable copying fee which the Secretary may establish" after "upon written request", and

(ii) by inserting before the period at the end the following: ", but only in a form which does not permit identification of individual suppliers".

(D) The last sentence of section 1866(a)(2)(A) of the Social Security Act, as added by section 4062(d)(4) of OBRA, is amended by striking "section 1834(a)(2)" and inserting "section 1834(a)(1)(B)".

(E) The matter added by section 4062(d)(3)(A)(ii) of OBRA is amended by striking "and" before "(I)".

(2) SECTION 4063.—(A) Section 1842(b)(11)(C)(ii) of the Social Security Act, as amended by section 4063(a)(1)(A) of OBRA, is amended—

(i) by striking "implanted" and inserting "inserted", and

(ii) by inserting "or subsequent to" after "during".

(B) Subclause (IV) of section 1842(j)(1)(D)(ii) of the Social Security Act, as inserted by section 4063(a)(2)(A) of OBRA, is redesignated as subclause (V) and is amended by striking "is".

(C) Section 4063(a)(2)(B) of OBRA is amended by striking clause (ii) and by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(D) Section 1833(i)(2)(A)(iii) of the Social Security Act, as inserted by section 4063(b)(3) of OBRA, is amended—

(i) by striking "implantation" and inserting "insertion", and

(ii) by inserting "or subsequent to" after "during".

(E) Section 4063 of OBRA is amended by adding at the end the following new subsection:

"(e) PREVENTION OF ADDITIONAL BILLINGS FOR IOLS.—

"(1) Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

" '(6) Any person, other than a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(2) Section 1832(a)(2)(F)(i) of such Act (42 U.S.C. 1395k(a)(2)(F)(i)) is amended by inserting '(including intraocular lens in cases described in section 1833(i)(2)(A)(iii))' after 'services' each place it appears.".

(3) SECTION 4064.—(A) Section 4064(a) of OBRA is amended by striking all that follows the first dash and inserting the follow-

ing: "Paragraph (2) of section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

"(1) by inserting '(A)(i)' after '(2)';

"(2) in the second sentence—

"(A) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

"(B) by designating such sentence as subparagraph (B); and

"(3) by adding at the end of subparagraph (A)(i), as designated under paragraph (1), the following new clause:

"(ii) Notwithstanding any other provision of this subsection—

"(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988, and

"(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988.".

(B) Section 4064(b)(1) of OBRA is amended—

(i) by striking "1833(h)(2) of the Social Security Act (42 U.S.C. 1395l(h)(2))" and inserting "1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)), as amended by subsection (a),";

(ii) by striking "the following: 'In establishing fee schedules under the first sentence of this paragraph with respect to" and inserting "the following new clause:

" '(iii) In establishing fee schedules under clause (i) with respect to"; and

(iii) by moving the indentation of all the matter added following "with respect to" 2 ems to the left.

(C) The clause added by section 4064(b)(1) of OBRA, as amended by subparagraph (A), is amended by inserting before the period at the end the following: ", and such reduced fee schedules shall serve as the base for 1989 and subsequent years".

(D) Section 1833(h)(4)(B)(ii) of the Social Security Act, as amended by section 4064(b)(2)(B) of OBRA, is amended by inserting "after" before "March".

(E) Section 4064(c) of OBRA is amended by striking all that follows the dash and inserting the following: "Section 1833(h)(1)(D) of such Act is amended by inserting ', in a sole community hospital (as defined in the last sentence of section 1886(d)(5)(C)(ii)),' after 'a hospital laboratory'.".

(F) Section 4064(c) of OBRA is amended by inserting "(1)" after the dash and by adding at the end the following new paragraph:

"(2) The amendment made by paragraph (1) shall apply with respect to diagnostic laboratory tests furnished on or after April 1, 1988.".

(G) Section 1846 of the Social Security Act, as added by section 4064(d)(1) of OBRA, is amended—

(i) in subsection (a)—

(I) by striking "certified" and "certification" and inserting "approved" and "approval", respectively,

(II) by inserting "or for coverage" after "conditions of participation", and

(III) by striking "cancelling immediately the certification of the provider or clinical laboratory" and inserting "terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory";

(ii) in subsections (b)(1)(A) and (b)(2)(A)(iv), by striking "certified";

(iii) in subsection (b)(2)(A)(ii), by striking "civil fines and penalties" and inserting "civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance";

(iv) in subsection (b)(2)(A), by adding at the end the following new sentence:

"The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(v) in subsection (b)(2)(A)(iii), by striking "certification";

(vi) in subsection (b)(2)(A)(iv), by striking "provided on or after the date in" and inserting "furnished on or after the date on"; and

(vii) in subsection (b)(3), by striking "fines" and inserting "penalties" each place it appears.

(H) The matter inserted in section 1861(s) of the Social Security Act by section 4064(e)(1) of OBRA is amended by inserting a comma after "year".

*(4) SECTION 4066.—(A) The heading of section 4066 of OBRA is amended by inserting "**AND OTHER DIAGNOSTIC TESTS**" after "**RADIOLOGY**".*

(B) The item relating to section 4066 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4066. Payments to hospital outpatient departments for radiology and other diagnostic tests.".

(C) Section 1833(n) of the Social Security Act, as added by section 4066(a)(2) of OBRA, is amended—

(i) in paragraph (1)(A), by striking "beginning on or after October 1, 1988, under this part for services described in subsection (a)(2)(E)" and inserting "for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989,";

(ii) in paragraph (1)(B)(i)(II), by inserting "or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established" after "the prevailing charge"; and

(iii) by amending subclauses (I) and (II) of paragraph (1)(B)(ii) to read as follows:

"(I) The term 'cost proportion' means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in

fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990.

"(II) The term 'charge proportion' means 100 percent minus the cost proportion.".

(5) SECTION 4067.—Section 1833(f) of the Social Security Act, as inserted by section 4067(a) of OBRA, is amended by striking "medicare economic index (referred to in the fourth sentence of section 1842(b)(3)) applicable to physicians' services" and inserting "MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4))".

(6) SECTION 4068.—The last sentence of section 1135(d)(3) of the Social Security Act, as added by section 4068(b)(1) of OBRA, is amended by striking "speciality" and inserting "specialty".

(h) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PART B ELIGIBILITY AND BENEFITS CHANGES).—

(1) SECTION 4070.—(A) The last sentence of section 1833(c) of the Social Security Act, as added by section 4070(a)(2) of OBRA, is amended by striking "prescribing or monitoring prescription drugs" and inserting "monitoring or changing drug prescriptions".

(B) Section 1861(ff) of the Social Security Act, as added by section 4070(b)(2) of OBRA, is amended—

(i) by inserting before such subsection the following heading:

"Partial Hospitalization Services", and

(ii) in paragraph (3), by striking "hospital-based or hospital-affiliated (as defined by the Secretary)" and inserting "furnished by a hospital to its outpatients".

(2) SECTION 4071.—Section 1861(s)(10)(A) of the Social Security Act, as amended by section 4071(a) of OBRA, is amended by inserting ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987," before "influenza vaccine".

(3) SECTION 4072.—(A) Section 1861(s)(12) of the Social Security Act, as amended by section 4072(a) of OBRA, is amended by inserting "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987," after "(12)".

(B) Section 4072(b) of OBRA is amended—

(i) by striking "by inserting after subsection (e)" and inserting "by adding at the end, as previously amended,", and

(ii) by redesignating the subsection added by such section as subsection (o).

(4) SECTION 4073.—Section 4073 of OBRA is amended—

(A) by striking paragraph (1) of subsection (b);

(B) in paragraph (2) of subsection (b)—

(i) by redesignating such paragraph as paragraph (1);

(ii) by inserting "and" at the end of subparagraph (A);

(iii) by striking subparagraph (B);

(iv) in the matter added by subparagraph (C)—

(I) by striking "and (I)" and inserting "(K)",

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be",

(III) by striking "but in no event more than" and inserting "but in no event shall such fee schedule exceed", and

(IV) by striking the semicolon and inserting a comma; and

(v) by redesignating subparagraph (C) as subparagraph (B);

(C) in paragraph (3) of subsection (b)—

(i) by inserting ", as previously amended," after "at the end",

(ii) by redesignating such paragraph as paragraph (2),

(iii) by redesignating the subsection added by such paragraph as subsection (p), and

(iv) by adding at the end of the subsection added by such paragraph the following: "Except for deductible and coinsurance amounts applicable under section 1833, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(D) in the subsection added by subsection (c)—

(i) by redesignating such subsection as subsection (gg), and

(ii) in paragraph (1), by striking "his" and inserting "the nurse-midwife's" and by striking "physician's" and inserting "physicians' "; and

(E) in the matter inserted by subsection (d)(1), by striking "section 1861(ff)" and inserting "section 1861(gg)".

(5) SECTION 4074.—Section 4074 of OBRA is amended—

(A) in the matter inserted by subsection (a)(1), by striking "(ff)" and inserting "(hh)", and

(B) by redesignating the subsection added by subsection (b) as subsection (hh).

(6) SECTION 4076.—Subsection (a) of section 4076 of OBRA is amended to read as follows:

"(a) SERVICES COVERED.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by inserting '(I)' before 'in a hospital' and by striking 'or as an assistant at surgery' and inserting ', (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area,'.".

(7) SECTION 4077.—Section 4077(b) of OBRA is amended—

(A) in paragraph (1), by inserting "by section 4073(a) of this title" after "as amended";

(B) by striking paragraph (2);

(C) in paragraph (3)—

(i) by striking "1395k(a)(1))" and inserting "1395l(a)(1)),

(ii) by striking subparagraphs (A) and (B),

(iii) in subparagraph (C), by striking "(I)" and inserting "(K)" and by redesignating such subparagraph as subparagraph (A),

(iv) in subparagraph (D), by striking "subparagraph:" and inserting "clause:" and by redesignating such subparagraph as subparagraph (B), and

(v) in the matter added by subparagraph (B), as so redesignated—

(I) by striking "(J)" and inserting "(L)", and

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be";

(D) in paragraph (4), by striking "section 4073(b)(3)" and inserting "4073(b)(2)";

(E) in paragraph (5), by redesignating the subsection (gg) added by such paragraph as subsection (ii); and

(F) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.

(8) SECTION 4079.—Section 4079(c)(1) of OBRA is amended by striking "subsection (d)" and inserting "subsection (e)".

(i) PROVISIONS RELATING TO SUBPART D OF PART 3 OF SUBTITLE A OF TITLE IV (OTHER PART B PROVISIONS).—

(1) SECTION 4081.—(A) Section 1842(h)(3)(B) of the Social Security Act, as added by section 4081(a) of OBRA, is amended—

(i) in the second sentence—

(I) by striking "claims" and inserting "payment", and

(II) by striking "including such information as the Secretary determines is generally provided" and inserting "shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order";

(ii) in the third sentence, by striking "arrangements" and inserting "agreements"; and

(iii) in the fourth sentence—

(I) by inserting "by a carrier" after "under this subparagraph", and

(II) by inserting before the period at the end the following: ", and such user fees shall be collected and retained by the carrier".

(B) Section 4081(b)(2) of OBRA is amended by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively, and by inserting before subparagraph (B), as so redesignated, the following:

"(A) in the matter before paragraph (1), by inserting '(or, with respect to paragraph (3), the issuer of the policy)' after 'he finds that such policy',".

(C) Section 1882(c)(3) of the Social Security Act, as inserted by section 4081(b)(2)(C) of OBRA, is amended—

(i) in subparagraph (A), by striking "claims form" each place it appears and inserting "claim form" in the first 2 places and "notice" in the third place,

(ii) in subparagraph (B)(i), by inserting "under the policy" after "payment determination", and

(iii) in subparagraph (B)(ii), by striking "appropriate payment" and inserting "payment covered by such policy".

(D) Section 4081(c)(2)(B)(i) of OBRA is amended by striking "medical" and inserting "medicare".

(E) Section 4081(c)(2)(B)(ii) of OBRA is amended by inserting "or which has not enacted such legislation before July 1, 1988," after "in which such legislation may be considered".

(2) SECTION 4082.—Section 4082(c) of OBRA is amended—

(A) by striking "1842(b)(5) of such Act (42 U.S.C. 1395u(b)(5)" and inserting "1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2))", and

(B) in paragraph (1), by striking "(5)" and inserting "(2)".

(3) SECTION 4084.—Section 4084 of OBRA is amended by adding at the end the following new subsection:

"(c) ADDITIONAL TECHNICAL CORRECTIONS.—

"(1) Section 1861(bb)(2) of the Social Security Act (42 U.S.C. 1395x(bb)(2)) is amended by adding at the end the following: 'Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.'.

"(2) Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by striking 'lesser of the actual charge' and inserting 'least of the actual charge, the prevailing charge that would be recognized if the services had been performed by an anesthesiologist,'.

"(3) The amendments made by this subsection shall apply to services furnished after December 31, 1988.".

(4) SECTION 4085.—(A) Section 1845(f) of the Social Security Act, as added by section 4085(a) of OBRA, is amended—

(i) in paragraph (1), by striking "October 1st" and inserting "December 31st", and

(ii) in paragraph (2), by striking "July 1st of the following year" and inserting "the later of (A) July 1st of the following year, or (B) 45 days after the date of a reasonable charge update".

(B) Subparagraph (D) of section 1833(h)(5) of the Social Security Act, as added by section 4085(b)(1) of OBRA, is amended—

(i) by striking "If a person" and all that follows through "under subparagraph (C)" and inserting the following: "A person may not bill for a clinical diagnostic laboratory test performed by a laboratory, other than a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence", and

(ii) by striking "section 1842(j)(2)" and inserting "paragraphs (2) and (3) of section 1842(j) in the same manner such paragraphs apply with respect to a physician".

(C) Section 4085(i) of OBRA is amended—

(i) in the matter inserted by paragraph (1)(A), by inserting a comma after "assignment-related basis";

(ii) in paragraph (1), by striking subparagraph (B);

(iii) in paragraph (11), by striking "9367(a)" and inserting "4072(a)";

(iv) in paragraph (21)(D)(i), by inserting "by" after "(i)";

(v) in paragraph (21)(D)(ii), by striking "and by" and all that follows up to the semicolon; and

(vi) by adding at the end the following:

"(22)(A) Section 1832(a)(2)(F)(ii) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)(ii)) is amended by striking 'an assignment described in section 1842(b)(3)(B)(ii)' and inserting 'payment on an assignment-related basis'.

"(B) Section 1833(h)(5) of such Act (42 U.S.C. 1395l(h)(5)) is amended, in each of subparagraphs (A) and (C), by striking 'on the basis of an assignment' and all that follows through '1870(f)(1),' and inserting 'on an assignment-related basis'.

"(C) Section 1842(b)(7)(B)(iii) of such Act (42 U.S.C. 1395u(b)(7)(B)(ii)) is amended by striking 'the basis of' and all that follows through '1870(f)(1)' and inserting 'an assignment-related basis'.

"(23) Section 1833(l)(5)(B)(ii) of such Act (42 U.S.C. 1395k(l)(5)(B)(ii)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(24) The fourth sentence of section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended by striking 'physician services' and 'physicians services' and inserting 'physicians' services' in both places.

"(25) Section 1842(b)(12)(C) of such Act (42 U.S.C. 1395u(b)(12)(C)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.".

"(26) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)(B)) is amended—

"(A) by striking 'title' each place it appears and inserting 'Act', and

"(B) in subparagraph (B)—

"(i) by striking 'the imposition of',

"(ii) by inserting 'and assessments' after 'such penalties', and

"(iii) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than the *first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).'.".*

"(27) Section 1842(l)(1)(C)(i) of such Act (42 U.S.C. 1395u(l)(1)(C)(i)) is amended by inserting 'the physician establishes that' after '(i)'.

"(28) Section 1866(g) of such Act (42 U.S.C. 1395cc(g)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.".

(D)(i) Section 1862(e) of the Social Security Act (42 U.S.C. 1395y(e)) is amended—

(I) by striking "or section 1128A" and inserting ", 1128A, 1156, 1842(j)(2), or 1867(d)",

(II) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and

(III) by inserting "(1)" after "(e)".

(ii) Section 1890 of the Social Security Act, as added by section 10 of Public Law 100-93, is amended—

(I) by striking its heading;

(II) by striking "SEC. 1890" and inserting "(2)";

(III) by inserting "1842(j)(2)," before "1862(d),";

(IV) by striking "or 1866" and inserting "1866, or 1867(d)"; and

(V) by transferring and adding such provision at the end of section 1862(e) of such Act.

(j) CORRECTIONS TO PART 4 OF SUBTITLE A OF TITLE IV (RELATING TO PEER REVIEW ORGANIZATIONS).—

(1) SECTION 4091.—Section 4091(a)(1)(B) of OBRA is amended by striking "renewals occurring" and inserting "contracts expiring".

(2) SECTION 4093.—Section 1154(a)(3) of the Social Security Act, as amended by section 4093(a) of OBRA, is amended by amending the last sentence to read as follows:

"(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).".

(3) SECTION 4094.—(A) Section 4094(a) of OBRA is amended by striking "subparagraph (B)" and inserting "subparagraph (A)".

(B) Section 1154(a)(15) of the Social Security Act, as added by section 4094(b) of OBRA, is amended by striking "at at" and inserting "in at".

(4) SECTION 4096.—(A) Section 4096(a)(1)(A) of OBRA is amended by striking "(b)(3)(ii)" and inserting "(b)(3)(B)(ii)".

(B) Section 1870(f) of the Social Security Act, as amended by section 4096(a)(2) of OBRA, is amended by striking "specified in subclauses (I) and (II) of " and inserting "of assignment specified in".

(C) Sections 1154(e)(3)(A)(i) and 1154(e)(3)(B) (42 U.S.C. 1320c-3(e)(3)(A)(i), 1320c-3(e)(2)(B)), as amended by section 4096(c) of OBRA, are each amended by striking "or (2)" before "paragraph (2)".

(5) SECTION 4097.—Section 4097(b) of OBRA is amended by striking "1866(a)(4)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(4)(C)(ii))" and inserting "1866(a)(3)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(3)(C)(ii))".

(k) CORRECTIONS TO SUBTITLE B OF TITLE IV (RELATING TO MEDICAID).—

(1) TABLE OF CONTENTS.—The table of contents of title IV of OBRA is amended by striking the item relating to section 4105 and by redesignating the items relating to sections 4106 and 4107 as relating to sections 4105 and 4106, respectively.

(2) SECTION 4101.—Section 1916(c)(1) of the Social Security Act, as inserted by section 4101(d)(1)(C) of OBRA, is amended by striking "nonfarm".

(3) SECTION 4102.—(A) Section 1915(d)(5)(B) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended—

(i) in clause (iii)(III), by striking "75" and inserting "65", and

(ii) by inserting before "Effective on" the following: "The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.".

(B) Section 1915(d)(5)(C)(i) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended—

(i) by striking "(4)(B)," and inserting "(4), and", and

(ii) by striking ", and services furnished" and all that follows through "subsection (c)".

(4) SECTION 4103.—Section 1905(a)(5)(B) of the Social Security Act, as inserted by section 4103(a) of OBRA, is amended by striking "subparagraph" and inserting "clause".

(5) SECTION 4104.—(A) Paragraph (1) of section 4104(1) of OBRA is amended to read as follows:

"(1) by striking ', or' at the end of subclause (IX) and inserting a semicolon and by inserting 'or' at the end of subclause (X); and".

(B) Section 1902(a)(10)(A)(ii)(XI) of the Social Security Act, as added by section 4104(2) of OBRA, is amended—

(i) by striking "are more restrictive" and inserting "may be more restrictive", and

(ii) by striking the period at the end and inserting a semicolon.

(6) SECTION 4112.—(A) Section 4112 of OBRA is amended—

(i) in subsection (a)(2)(A)—

(I) by striking "such date" and inserting "April 1, 1989", and

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1989" before the period;

(ii) in subsection (a)(2)(B)—

(I) by striking "such date" and inserting "April 1, 1990", and

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1990" before the period;

(iii) the undesignated paragraph at the end of subsection (a) is amended—

(I) by striking "June 30 of each year in which the State is required to submit" and inserting "90 days after the date a State submits",

(II) by indenting all of such paragraph 2 ems, and

(III) by designating the first two sentences thereof as paragraph (3) and the last sentence thereof as paragraph (4);

(iv) in subsection (b)(2), by striking "the State plan" and inserting "a State plan";

(v) in subsection (b)(3)(B)(i), by inserting ", less the portion of any cash subsidies described in clause (i)(II) in the period reasonably attributable to inpatient hospital services" after "charity care in a period";

(vi) in subsection (c)—

(I) by striking "paragraphs (2)(A) and (2)(B)" and inserting "paragraphs (1)(B) and (2)(A) of subsection (a)",

(II) by striking "paragraph (2)(A)" and "paragraph (2)(B)" and inserting "such paragraph (1)(B)" and "such paragraph (2)(A)", respectively,

(III) in paragraph (1), by inserting "at least" after "equal to",

(IV) in paragraph (2), by inserting "(without regard to the election made by a State under subsection (b)(1))" after "payment) and",

(V) in the matter after paragraph (2), by inserting "at least" before "one-third" and before "two-thirds", and

(VI) by adding at the end the following new sentences: "In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased per-

centage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital."; and

(vii) in subsection (e)—

*(I) by inserting "(1)" after "*Special Rule.—*",*

(II) by inserting "based on a pooling arrangement involving a majority of the hospitals participating under the plan" after "payment adjustments", and

(III) by adding at the end the following new paragraph:

"(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a State-wide basis, during the 3-year period beginning on July 1, 1988—

"(A) the requirements of subsections (b) and (c) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied, and

"(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas.".

(B) Section 4112 of OBRA is further amended—

(i) by striking "(a) Implementation of Requirement.—*" and inserting the following:*

"(a) In General.—*Title XIX of the Social Security Act is amended—*

"(1) by redesignating section 1923 as section 1924, and

"(2) by inserting after section 1922 the following new section:

" 'ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

" 'Sec. 1923. (a) Implementation of Requirement.—*' ";*

(ii) in subsection (a)(1), by striking "A State's plan under title XIX of the Social Security Act" and inserting "A State plan under this title";

(iii) in subsection (a)(1), by striking "of such Act";

(iv) in subsection (a), by striking "of Health and Human Services" each place it appears;

(v) in the matter following paragraph (2)(B) of subsection (a), by striking "of the Social Security Act";

(vi) in subsections (b) and (c), by striking "under title XIX of the Social Security Act" each place it appears and inserting "under this title";

(vii) in subsection (d)(2)(B), by striking "of the Social Security Act";

(viii) in subsections (b)(2), (b)(3), and (d)(2)(B), by striking double quotation marks enclosing terms and inserting single quotation marks;

(ix) by placing opening double quotation marks at the beginning of any matter with an initial paragraph indentation (beginning with subsection (a)(1)) and closing double quotation marks at the end of subsection (e); and

(x) by adding at the end the following:

"(b) Conforming Amendment.—Section 1903(i)(3) of such Act (42 U.S.C. 1396b(i)(3)) is amended by inserting '(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)' before 'to the extent'.".

(7) Section 4113.—Section 4113 of OBRA is amended—

(A) in the matter inserted by subsection (a)(1)(B)—

(i) by moving the left margin of the matter 2 ems to the left, and

(ii) by striking "subparagraph (G)" and inserting "subparagraph (E) or (G)";

(B) in the matter inserted by subsection (a)(2), by striking "paragraph (2)(G) or (6)" and inserting "paragraph (2)(B)(iii), (2)(E), (2)(G), or (6)";

(C) in subsection (b)(2)(ii), by striking "such"; and

(D) by striking subsection (d) and redesignating subsection (e) as subsection (d).

(8) Section 4114.—(A) Section 4114 of OBRA is amended in paragraph (1), by striking " '(1)' " and inserting " '(o)(1)' ".

(B) Section 1905(o)(1)(B) of the Social Security Act, as added by section 4114(3) of OBRA, is amended—

(i) by striking "only", and

(ii) by striking "immunodeficiency syndrome" and inserting "immune deficiency syndrome (AIDS)".

(9) Section 4115.—(A) Section 4115 of OBRA is amended—

(A) in subsection (b)(4)(B), by striking "program" and inserting "Program",

(B) in subsection (c)—

(i) by inserting "under section 9121 of this Act" after "Upon approval", and

(ii) by striking "1916, and 1924" and inserting "1902(e)(1), and 1916", and

(C) by adding at the end the following:

"(d) Extension of Texas State Waiver.—Section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking 'January 1, 1989' and inserting 'January 1, 1990'.".

(10) Section 4118.—(A) Section 1915(c)(10) of the Social Security Act, as added by section 4118(b) of OBRA, is amended—

(i) by striking "No waiver under this subsection shall limit by an amount less than 200" and inserting "The Secretary shall not limit to fewer than 200", and

(ii) by striking "under such waiver" and inserting "under a waiver under this subsection".

(B) Section 4118(e) of OBRA is amended—

(i) in paragraph (3), by striking "amendment" and inserting "amendments", and

(ii) in paragraph (1)—

(I) by inserting "(A)" after "(1)",

(II) by striking "1128A(a)(1)" and "1320a-7(a)(1))" and inserting "1128(a)" and "1320a-7(a))", respectively, and

(III) by adding at the end the following:

"(B) Section 1128A of such Act is amended by adding at the end the following new subsection:

" '(l) A principal is liable under this section for the actions of the principal's agent acting within the scope of the agency.'.".

(C) Section 1128(d)(3)(B)(ii) of the Social Security Act, as added by section 4118(e)(2)(B) of OBRA, is amended by striking "under a program".

(D) Section 4118(e) of OBRA is amended by redesignating paragraph (3) as paragraph (14) and by inserting after paragraph (2) the following new paragraphs:

"(3) Section 1128(b)(8)(A)(i) of such Act is amended by inserting after '(A)(i)' the following: 'who has a direct or indirect ownership or control interest of 5 percent or more in the entity or'.

"(4) Section 1128(d) of such Act is amended—

"(A) in paragraph (1), by striking 'subsection (b)' and inserting 'this section and section 1128A', and

"(B) in paragraph (3)(A), by striking 'under a program'.'

"(5) Section 1128(i) of such Act is amended—

"(A) in the matter before paragraph (1), by striking 'a physician or other individual' and inserting 'an individual or entity',

"(B) in paragraphs (1) through (4), by striking 'physician or other individual' each place it appears and inserting 'individual or entity', and

"(C) in paragraph (4), by striking 'first offender or other program' and inserting 'first offender, deferred adjudication, or other arrangement or program'.

"(6) Section 1128A(a)(1)(D) of such Act is amended—

"(A) by striking 'excluded under' and inserting 'excluded from', and

"(B) by inserting 'or as a result of the application of the provisions of section 1842(j)(2) or section 1867(d)(2)' after 'or 1866(b)'.

"(7) The second sentence of section 1128A(c)(1) of such Act is amended—

"(A) by inserting ', request for payment, or other occurrence described in this section' after 'any claim', and

"(B) by inserting ', the request for payment was made, or the occurrence took place' after 'claim was presented'.

"(8) Section 1128A(i) of such Act is amended, in the matter before paragraph (1), by striking 'subsection' and inserting 'section'.

"(9) Section 1128A(i)(1) of such Act is amended by inserting 'or title XX' after 'title V'.

"(10) Section 1128A of such Act is further amended—

"(A) in the matter in subsection (a) before paragraph (1), by inserting ', but excluding a beneficiary, as defined in subsection (i)(5)' after 'other entity';

"(B) in subsection (i)(2), by striking 'submitted by' and all that follows through the end and inserting 'for payments for items and services under title V, XVIII, XIX, or XX of this Act.', and

"(C) by adding at the end the following new paragraph:

" '(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under title V, XVIII, XIX, or XX but does not include a provider, supplier, or practitioner.'.

"(11) Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

"(A) in subparagraph (A), by striking 'in the State plan under this title pursuant to section 1128 or section 1128A' and inserting 'under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)', and

"(B) in subparagraph (B), by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' and inserting 'from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(12) Section 504(b)(6) of such Act (42 U.S.C. 704(b)(6)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(13) Section 2005(a)(9) of such Act (42 U.S.C. 1397d(a)(9)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.".

(E) Section 4118(f)(1) of OBRA is amended by striking "4111(g)(8)" and inserting "4211(h)(8)".

(F) Section 4118(g)(1)(B) of OBRA is amended by striking "insert" and inserting "inserting".

(G) Section 4118(h) of OBRA is amended—

(i) by inserting a dash after "EXPENSES.";

(ii) in paragraph (1), by striking "Section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)) is amended" and inserting "Sections 1902(a)(17) and 1903(f)(2) of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396b(f)(2)) are each amended";

(iii) in paragraph (2), by striking "(2) The amendment made by paragraph (1)" and inserting "(3) The amendments made by this subsection", and

(iv) by inserting after paragraph (1) the following new paragraph:

"(2) The first sentence of section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting after 'as recognized under State law' the following: 'regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof'.".

(H) Section 1915(c)(7)(B) of the Social Security Act, as added by section 4118(k) of OBRA, is amended by inserting before the period at the end the following: ", without regard to the availability of beds for such inpatients".

(I) Section 4118(l)(1) of OBRA is amended by inserting ", as redesignated by section 4102(a)," after "1396n(h))".

(J) Section 9414(b)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(o)(1)(C) of OBRA, is amended by striking "nonfarm".

(K) Section 4118(o)(2)(A) of OBRA is amended by inserting "each place it appears" before "and inserting".

(L) Section 4118(p)(9) of OBRA is amended by striking "1925(a)" and "(4111(a))" and inserting "1923(a)" and "4211(a)", respectively.

(M) Section 4118(p) of OBRA is amended by adding at the end the following new paragraph:

"(11) Paragraph (5) of section 9432(c) of the Omnibus Budget Reconciliation Act of 1986 is amended to read as follows:

" '(5) The Secretary shall submit an interim report on the results of the study, including an analysis of the geographic variations under paragraph (2), to the Congress not later than January 1, 1990, and shall report the final results of the study to the Congress not later than January 1, 1992.'.".

*(11) O*MITTED SECTION.*—(A) Part 2 of subtitle B of title IV of OBRA is amended by adding at the end the following new section:*

"SEC. 4119. STUDY OF MEANS OF RECOVERING COSTS OF NURSING FACILITY SERVICES FROM ESTATES OF BENEFICIARIES.

"The Secretary of Health and Human Services shall study the means of recovering amounts from estates of deceased medicaid beneficiaries (or the estates of the spouses of such deceased beneficiaries) to pay for the medical assistance for skilled nursing facility or intermediate care facility services furnished, under title XIX of the Social Security Act, to such medicaid beneficiaries. The Secretary shall report to Congress, not later than December 31, 1988, on such means, and include appropriate recommendations for changes in legislation.".

(B) The table of contents of title IV of OBRA is amended by inserting after the item relating to section 4118 the following new item:

"Sec. 4119. Study of means of recovering costs of nursing facility services from estates of beneficiaries.".

*(12) M*EDICAID CONFORMING AMENDMENT TO SECTION 4014 OF OBRA.*—(A) Paragraph (5) of section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended to read as follows:*

"(5)(A) If the Secretary determines that an entity with a contract under this subsection—

"(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

"(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services; or

"(iv) misrepresents or falsifies information that is furnished—

"(I) to the Secretary or the State under this subsection, or

"(II) to an individual or to any other entity under this subsection,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

"(B) The remedies described in this subparagraph are—

"(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

"(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) The amendment made by subparagraph (A) shall apply to actions occurring on or after the date of the enactment of this Act.

(13) TREATMENT OF EDUCATIONALLY-RELATED SERVICES.—(A) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (b) the following new subsection:

"(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to part B of the Education of the Handicapped Act or furnished to a handicapped infant or toddler because such services are includ-

ed in the child's individualized family service plan adopted pursuant to part H of such Act.".

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(14) CLARIFICATION OF TERM "INSTITUTION FOR MENTAL DISEASES".—(A) Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by inserting after subsection (h) the following new subsection:

"(i) The term 'institution for mental diseases' means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.".

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(15) ELIGIBILITY VERIFICATION TECHNICAL CORRECTION.—(A) Section 1137 of the Social Security Act (42 U.S.C. 1320b-7) is amended by adding at the end the following new subsection:

"(f) Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).".

(B) The amendment made by subparagraph (A) shall apply as if it were included in the enactment of section 9406 of the Omnibus Budget Reconciliation Act of 1986.

(16) TECHNICAL CORRECTIONS RELATING TO PRESUMPTIVE ELIGIBILITY.—(A) Section 1920(d)(1)(B) of the Social Security Act (42 U.S.C. 1396r-1(d)(1)(B)) is amended by striking "by a qualified provider" and inserting "by a provider that is eligible for payments under the State plan".

(B) Section 1920(b)(2)(D) of such Act (42 U.S.C. 1396r-1(b)(2)(D)) is amended—

(i) in clause (i)—

(I) in subclause (I), by striking "or section 330" and inserting ", 330, or 340" and by striking "or" at the end,

(II) in subclause (II), by striking the semicolon at the end and inserting ", or", and

(III) by adding after subclause (II) the following new subclause:

"(III) title V of the Indian Health Care Improvement Act;";

(ii) in clause (ii), by striking "or" at the end; and

(iii) by adding at the end the following new clause:

"(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).".

(C) The amendments made by this paragraph shall be effective as if they were included in section 9407(b) of the Omnibus Budget Reconciliation Act of 1986.

(17) WAIVER FOR CHILDREN INFECTED WITH AIDS OR DRUG DEPENDENT AT BIRTH.—(A) Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended—

(i) by redesignating subsection (f) as paragraph (2),

(ii) in subsection (e), by striking paragraph (2) and by redesignating such subsection as subsection (f),

(iii) by inserting after subsection (d) the following new subsection:

"(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as 'medical assistance' under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

"(B) Children described in this subparagraph are individuals under 5 years of age who—

"(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

"(ii) have such syndrome, or

"(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

"(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

"(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

"(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

"(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d)."; and

(iv) in subsection (h), by striking "or (d)" and inserting "(d), or (e)".

(B) Section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is amended by striking "(c) or (d)" each place it appears and inserting "(c), (d), or (e)".

(l) CORRECTIONS RELATING TO SUBTITLE C OF TITLE IV (NURSING HOME REFORM).—

(1) SECTION 4201.—(A) Section 1819 of the Social Security Act, as added by section 4201(a)(3) of OBRA, is amended—

(i) in subsection (b)(3)(C)(i)(I), by striking "October 1, 1990" the second place it appears and inserting "January 1, 1991";

(ii) in subsection (b)(4)(C)(i)—

(I) by inserting "licensed" after "24-hour",

(II) by striking "employ" and inserting "use", and

(III) by striking "during the day tour of duty (of at least 8 hours a day)" and inserting "at least 8 consecutive hours a day,";

(iii) in subsection (b)(5)(A), by striking "October 1, 1989" and all that follows through "July 1, 1989)" and inserting "January 1, 1990";

(iv) in subsection (e)(1)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(v) in subsection (e)(1)(B), by striking "March 1, 1990" and inserting "January 1, 1990";

(vi) in subsection (e)(2)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(vii) in subsection (e)(3), by striking "October 1, 1990" and inserting "October 1, 1989";

(viii) in subsection (e)(5), by striking "July 1, 1989" and inserting "July 1, 1990";

(ix) in subsection (f)(3), by striking "October 1, 1989" and inserting "October 1, 1988";

(x) in subsection (f)(6)(A), by striking "July 1, 1989" and inserting "January 1, 1989"; and

(xi) in subsection (f)(6)(B), by striking "October 1, 1990" and inserting "April 1, 1990".

(B) Section 4201(d) of OBRA is amended—

(i) by striking "AMENDMENT.—" and inserting "AMENDMENTS.—(1)",

(ii) by striking "1919(a)(2)" and inserting "1819(a)(1)", and

(iii) by adding at the end the following new paragraph:

"(2) Section 1861(n) of such Act (42 U.S.C. 1395x(n)) is amended by striking 'or (j)(1) of this section' and inserting 'or of section 1819(a)(1)'.".

(2) SECTIONS 4201 AND 4211.—(A) Sections 1819(b)(3)(A)(iv) and 1919(b)(3)(A)(iv) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under part A of this title" and by striking "in

the case of a resident eligible for benefits under part A of title XVIII", respectively.

(B) Sections 1819(b)(3)(A)(iii) and 1919(b)(3)(A)(iii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under title XIX," and "in the case of a resident eligible for benefits under this title,", respectively.

(C) Subclause (III) of each of sections 1819(b)(3)(B)(ii) and 1919(b)(3)(B)(ii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, is amended to read as follows:

> *"(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".*

(D) Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act, as added by section 4201(a)(3) of OBRA and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A), by striking ", who is not a licensed health care professional (as defined in subparagraph (E)),",

(ii) in subparagraph (A)(ii), by striking "such services" and inserting "nursing or nursing-related services", and

(iii) in subparagraph (G), by inserting "physical or occupational therapy assistant," after "occupational therapist,".

(E) Effective as of the date of the enactment of this Act and until the effective date of section 1819(c) of such Act, section 1861(j) of the Social Security Act is deemed to include the requirement described in section 1819(c)(3)(A) of such Act (as added by section 4201(a)(3) of OBRA).

(F) Sections 1819(c)(2)(A)(v) and 1919(c)(2)(A)(v) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "an allowable charge" and all that follows through the semicolon and inserting "for a stay at the facility;".

(G) Sections 1819(c)(6) and 1919(c)(6) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A)(ii), by striking "once the facility accepts" and inserting "upon", and

(ii) in subparagraph (B), by striking "a facility's acceptance of".

(H) Sections 1819(e)(2)(B) and 1919(e)(2)(B) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively are each amended by inserting after the first sentence the following sentence: "The State shall make available to the public information in the registry.".

(I) Sections 1819(e)(3), 1819(f)(3), 1919(e)(3), and 1919(f)(3) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) by inserting "AND DISCHARGES" after "TRANSFERS", and

(ii) by inserting "and discharges" after "transfers".

(J) Sections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(I) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "cognitive, behavioral and social care" and inserting "recognition of mental health and social service needs".

(K) Sections 1819(f)(7) and 1919(f)(7) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "patients" and inserting "residents".

(L)(i) Section 1819(f)(7)(B) of the Social Security Act, as added by section 4201(a)(3), is amended by striking "shall not" and inserting "shall".

(ii) Section 1919(f)(7)(B) of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended by striking "do not".

(3) SECTION 4211.—(A) Section 1919(b)(4)(C) of the Social Security Act, as inserted by section 4211(a) of OBRA, is amended—

(i) by striking "registered nurse" each place it appears and inserting "registered professional nurse";

(ii) by striking "employ" and inserting "use";

(iii) by striking "(ii) FACILITY WAIVERS.—" and all that follows through "(i) WAIVER" and inserting "(ii) WAIVER";

(iv) by striking "and subject to clause (ii)" and inserting "and subject to clause (iii)";

(v) by striking "(ii) ASSUMPTION" and inserting "(iii) ASSUMPTION"; and

(vi) in clause (iii), as so redesignated, by striking "excercise" and inserting "exercise".

(B) Section 1919(b)(5)(A) of the Social Security Act, as added by section 4211(a)(3) of OBRA, is amended by striking "subparagraph (E)" and inserting "subparagraph (F)".

(C) Effective as of the date of the enactment of this Act and until the effective date of section 1919(c) of such Act, section 1905(c) of the Social Security Act is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA).

(D) Section 1919 of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended—

(i) in subsection (e)(1)(A), by striking "September 1, 1988" and inserting "January 1, 1989";

(ii) in subsection (e)(1)(B), by striking "September 1, 1990" and inserting "January 1, 1990";

(iii) in subsection (e)(7)(E), by striking "October 1, 1988" and inserting "April 1, 1989"; and

(iv) in subsection (f)(2), by striking "July 1, 1988" and inserting "September 1, 1988".

(E) Section 1902(a)(28)(D)(i) of the Social Security Act, as amended by section 4211(b)(1)(B) of OBRA, is amended by striking "1919(f)" and all that follows through "instrument)" and inserting "1919(e)".

(F) Section 4211(d)(2) of OBRA is amended by striking "For calendar quarters during fiscal years 1988 and 1989" and in-

serting "For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988)".

(G) Section 4211(h)(10)(G) of OBRA is amended by adding before the period at the end the following: ", and by striking 'skilled nursing facility or intermediate care facility' in subparagraph (B) and inserting 'nursing facility' ".

(H) Section 4211(h)(2) of OBRA is amended—

(i) in subparagraph (C), by striking "inserting 'nursing facilities' " each place it appears and inserting "inserting 'nursing facilities and for intermediate care facilities for the mentally retarded' ",

(ii) in subparagraph (D)(i), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility or intermediate care facility for the mentally retarded' ", and

(iii) in subparagraph (D)(ii), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility services or services in an intermediate care facility for the mentally retarded' ".

(I) Subparagraph (B) of section 4211(h)(12) of OBRA is amended to read as follows:

"(B) in subsection (c)(2)(B)(ii), by striking 'skilled' each place it appears.".

(4) SECTION 4202.—Section 1819(g)(2)(C)(i) of the Social Security Act, as added by section 4202(a) of OBRA, is amended by striking "October 1, 1990" and inserting "January 1, 1990".

(5) SECTIONS 4202 AND 4212.—Sections 1819(g) and 1919(g) of the Social Security Act, as added by sections 4202(a)(2) and 4212(a) of OBRA, respectively, are amended--

(A) in paragraph (1)(C), by striking ", review," and inserting "and timely review";

(B) in the first sentence of paragraph (1)(C), by inserting "or by another individual used by the facility in providing services to such a resident" after "a nursing facility";

(C) by striking the second sentence of paragraph (1)(C) and inserting the following: "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority.";

(D) in paragraph (1)(D), by striking "to establish standards under subsection (f)" and inserting "to issue regulations to carry out this subsection";

(E) in paragraph (2)(A)(i), by amending the third sentence to read as follows: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(F) in paragraph (3)(D) (relating to special surveys of compliance, as redesignated by paragraph (6)(A) in the case of section 1919(g)), by striking "on that basis" and inserting "on the basis of that survey"; and

(G) in paragraph (4), by striking "chronically".

(6) SECTION 4212.—(A) Section 1919(g)(3) of the Social Security Act, as added by section 4212(a) of OBRA, is amended by redesignating the second subparagraph (C) (relating to special surveys of compliance) as subparagraph (D).

(B) Section 4212(b) of OBRA is amended to read as follows:

"(b) POSTING SURVEY RESULTS.—Section 1919(c) of such Act is amended by adding at the end the following new paragraph:

" '(7) POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).'."

(C) Section 1902(a)(33)(B) of the Social Security Act, as amended by section 4212(d)(3) of OBRA, is amended by striking "1919(d)" and inserting "1919(g)".

(D) Section 4212(e)(1)(B) of OBRA is amended by inserting "provided" after "services" each place it appears.

(E) Section 4212(e) of OBRA is amended by adding at the end the following new paragraph:

"(5) Section 1922(e) of such Act, as redesignated and transferred by section 4211(a)(2) of this Act, is amended by striking '1910(c)' in paragraphs (1) and (2)(A) and inserting '1910(b)'."

(7) SECTIONS 4203 AND 4213.—(A) Sections 1819(h)(2)(B)(ii) and 1919(h)(3)(C)(ii) of the Social Security Act, as added sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by striking "and the Secretary" and all that follows through "1128A." and inserting the following: ". The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) Sections 1819(h)(6) and 1919(h)(9) of the Social Security Act, as added by sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by inserting "by such facilities" after "shall be made available".

(8) SECTION 4213.—(A) Section 4213(a) of OBRA is amended by striking "as inserted by section 4201 and amended by section 4202" and inserting "as inserted by section 4211 and amended by section 4212".

(B) Section 1919(h) of the Social Security Act, as added by section 4213(a) of OBRA, is amended—

(i) in the last sentence of paragraph (1), by striking "(2)(A)(i)" and inserting "(2)(A)(ii)",

(ii) in the second sentence of paragraph (2)(B)(i), by striking "or otherwise", and

(iii) in paragraph (5), by striking "State and the Secretary" and inserting "State or the Secretary, respectively".

(C) Paragraph (1) of section 4213(b) of OBRA is amended by striking "1902" and all that follows through the end and in-

serting the following: "1902(i) of such Act (42 U.S.C. 1396a(i)) is amended—

"(A) in paragraph (1), by striking 'skilled nursing facility or intermediate care facility' and inserting 'intermediate care facility for the mentally retarded';

"(B) in paragraph (1), by striking 'the provisions of section 1861(j) or section 1905(c), respectively,' and inserting 'the requirements for such a facility under this title'; and

"(C) in paragraphs (2) and (3), by striking 'the provisions of section 1861(j) or section 1905(c) (as the case may be)' and inserting 'the requirements for such a facility under this title'.".

(9) SECTION 4204.—(A) Section 4204(a) of OBRA is amended by striking "extended care".

(B) Section 4204 of OBRA is amended—

(i) in subsection (a), by striking "made by this part" and inserting "made by sections 4201 and 4202 (relating to skilled nursing facility requirements and survey and certification requirements)",

(ii) by redesignating subsection (c) as subsection (d), and

(iii) by inserting after subsection (a) the following new subsection:

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act, the amendments made by section 4203 of this Act apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act.".

(10) SECTION 4214.—Section 4214 of OBRA is amended—

(A) by striking "(c) TRANSITIONAL RULE.—" and inserting "(2)",

(B) by inserting "of section 1919 of the Social Security Act" after "(b), (c), or (d)", and

(C) by redesignating subsection (d) as subsection (c).

(m) CORRECTIONS TO SUBTITLE E OF TITLE IV (RELATING TO RURAL HEALTH).—

(1) SECTION 4401.—Section 711(b)(1) of the Social Security Act, as added by section 4401 of OBRA, is amended by striking "section 4083 of the Omnibus Budget Reconciliation Act of 1987" and inserting "section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues)".

(2) SECTION 4403.—(A) Section 4403 of OBRA is amended—

*(i) in the heading, by striking "**EXPERIMENTS AND DEMONSTRATION PROJECTS RELATING TO RURAL HEALTH CARE ISSUES**" and inserting "**RESEARCH AND DEMONSTRATION PROJECTS ON RURAL AND INNER-CITY HEALTH ISSUES**";*

(ii) in subsection (a)—

(I) by striking "Set Aside.—" and inserting "Set Asides for Issues of Health Care in Rural Areas and In Inner-City Areas.—(1)",

(II) by striking "expended in each fiscal year" and all that follows through "1972" and inserting "annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990",

(III) by striking "experiments" and inserting "research";

(iii) by adding at the end the following new paragraph:

"(2) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to issues of providing health care in inner-city areas, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of inner-city hospitals and the impact of medicare policies on access to (and the quality of) health care in inner-city areas."; and

(iv) in subsection (b)—

(I) by striking "of experiments" and inserting "of research",

(II) by inserting "or to inner-city health issues" after "rural health issues", and

(III) by striking "experiments and".

(B) The item in the table of contents of OBRA relating to section 4403 is amended to read as follows:

"Sec. 4403. Set aside for research and demonstration projects on rural and inner-city health issues.".

(n) Corrections to Certain Health-Related Provisions in Title IX.—

(1) Section 9010.—The last sentence of section 226(b) of the Social Security Act, as added by section 9010(e)(3) of OBRA, is amended to read as follows: "In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term '36 months' in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read '15 months'.".

(2) Section 9115.—Section 9115(b) of OBRA is amended by striking "1902(l)" and inserting "1902(o)".

(3) Section 9119.—Section 9119 of OBRA is amended by adding at the end the following new subsection:

"(d) Conforming Amendments to Medicaid Program for the Medically Needy.—(1) Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

"(A) in subsection (a)—

"(i) by striking 'and' at the end of paragraph (48),

"(ii) by striking the period at the end of paragraph (49) and inserting '; and', and

"(iii) by inserting after paragraph (49) the following new paragraph:

" '(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples.'; and

"(B) by adding at the end the following new subsection:

" '(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

" '(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

" '(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

" '(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

" '(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

" '(ii) who is or are determined to be eligible for medical assistance under the State plan.

" '(2) The minimum monthly personal needs allowance described in this paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).'.

"(2) The amendments made by paragraph (1) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.".

(o) SUBTITLE D OF TITLE IV.—

(1) SECTION 4303.—Section 2115 of the Public Health Service Act—

(A) in subsection (i)(1), as added by section 4303(a) of OBRA, is amended by striking "from appropriations under subsection (i)" and inserting "by the Secretary from appropriations under subsection (j)", and

(B) in subsection (j), as added by section 4303(b) of OBRA, is amended by inserting "to the Department of Health and Human Services" after "to be appropriated".

(2) SECTION 4307.—Section 4307(3)(C) of OBRA is amended by striking "subsection (g)" and inserting "subsection (e), as redesignated by section 4303(d)(2)(A),".

(3) SECTION 4308.—(A) Subtitle D of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4308. TECHNICAL AMENDMENTS RELATING TO COURT OF CLAIMS PROCEDURES.

"(a) DUTIES OF SPECIAL MASTERS.—Section 2112(c)(2) of the Public Health Service Act (42 U.S.C. 300aa-12(a)) is amended—

"(1) by inserting ', shall prepare and submit to the court proposed findings of fact and conclusions of law,' after 'adjunct to the court',

"(2) by inserting 'and' at the end of subparagraph (C),

"(3) by striking ', and' at the end of subparagraph (D) and inserting a period, and

"(4) by striking subparagraph (E).

"(b) REQUIRING FILING OF APPEALS WITHIN 60 DAYS.—Section 2112(e) of such Act (42 U.S.C. 300aa-12(e)), as redesignated by section 4303(d)(2)(A), is amended by inserting 'within 60 days of the date of the judgment' after 'petition filed'.

"(c) CLARIFICATION ON TIMING OF BRINGING ADDITIONAL ACTIONS.—The second sentence of section 2121(a) of such Act (42 U.S.C. 300aa-21(a)) is amended by striking 'the entry of the court's judgment' and inserting 'the court's final judgment'.".

(B) The table of contents relating to title IV of OBRA is amended by inserting after the item relating to section 4307 the following new item:

"Sec. 4308. Technical amendments relating to Court of Claims procedures.".

Subtitle C—Miscellaneous Provisions

SEC. 421. MAINTENANCE OF EFFORT.

(a) IN GENERAL.—

(1) DUPLICATIVE PART A BENEFITS.—If an employer described in subsection (b)(1) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part A benefits (as defined in paragraph (3)(A)), the employer shall, during the period described in subsection (c)(1), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the actuarial value of the duplicative part A benefits during the period described in subsection (c)(1)(A).

(2) DUPLICATIVE PART B BENEFITS.—If an employer described in subsection (b)(2) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part B benefits (as defined in paragraph (3)(B)), the employer shall, during the period described in subsection (c)(2), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the actuarial value of the duplicative part B benefits during the period described in subsection (c)(1)(B).

(3) DUPLICATIVE BENEFITS DEFINED.—In this section:

(A) The term "duplicative part A benefits" means benefits which are duplicative of benefits under part A of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1989), but which were not duplicative of such

benefits as such part was in effect before the date of the enactment of this Act.

(B) The term "duplicative part B benefits" means benefits which are duplicative of benefits under part B of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1990, but excluding any such benefits with respect to covered outpatient drugs), but which were not duplicative of such benefits as such part was in effect before the date of the enactment of this Act.

(C) Duplicative part A benefits and duplicative part B benefits shall be determined under this section net of any premiums payable by employees (or retired former employees) attributable to the respective duplicative benefits.

(b) EMPLOYERS COVERED.—

(1) DUPLICATIVE PART A BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part A benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part A benefits.

(2) DUPLICATIVE PART B BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part B benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part B benefits.

(3) ELECTION.—For purposes of this section—

(A) IN GENERAL.—An employer may elect to compute the actuarial value of duplicative part A benefits and duplicative part B benefits either—

(i) on the basis of average actuarial values published by the Secretary under subparagraph (B)(i), or

(ii) on the basis of the actuarial value with respect to that employer, computed using guidelines published by the Secretary under subparagraph (B)(ii).

(B) COMPUTATION OF ACTUARIAL VALUES.—The Secretary of Health and Human Services, before the beginning of each of 4 years (beginning with 1989 for duplicative part A benefits and beginning with 1990 for duplicative part B benefits) shall—

(i) calculate and publish the national average actuarial value of duplicative part A benefits and duplicative part B benefits for 1988 and the year involved, and

(ii) guidelines for employers to use, under subparagraph (A)(ii), in computing the actuarial value of such duplicative benefits with respect to each employer for such years.

The guidelines published under clause (ii) shall include instructions to assist employers in determining whether or not *employers are described in paragraph (1) or (2) of this subsection.*

(c) EFFECTIVE PERIOD.—

(1) IN GENERAL.—

(A) DUPLICATIVE PART A BENEFITS.—Subsection (a)(1) shall only be effective during the period beginning on January 1, 1989, and ending on December 31, 1989, or, if later, the date specified in paragraph (2).

(B) DUPLICATIVE PART B BENEFITS.—Subsection (a)(2) shall only be effective during the period beginning on January 1, 1990, and ending on December 31, 1990, or, if later, the date specified in paragraph (2).

(2) EXTENSION TO COVER CURRENT COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees or retired former employees who are provided duplicative part A benefits or duplicative part B benefits under a collective bargaining agreement that is in effect on the date of enactment of this Act, the date specified in this paragraph is the date of the expiration of the agreement (determined without regard to any extension thereof agreed to after the date of the enactment of this Act).

(d) EXCLUSION OF MULTI-EMPLOYER PLANS.—This section shall not apply with respect to duplicative benefits provided under a plan—

(1) to which more than one employer is required to contribute, and

(2) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

SEC. 422. RATE REDUCTION FOR MEDICARE ELIGIBLE FEDERAL ANNUITANTS.

(a) IN GENERAL.—

(1) The Office of Personnel Management shall, in consultation with carriers offering health benefits plans contracted pursuant to section 8902 of title 5, United States Code, reduce the rates charged medicare eligible individuals participating in such health benefit plans, by the amount, prorated for each covered medicare eligible individual, of the estimated cost of medical services and supplies which, but for the amendments made by subtitle A of title I and subtitle A of title II of this Act, would have been payable by such plans.

(2) The reduced rates as provided under paragraph (1), shall apply as of the effective dates of the respective amendments.

(b) AUTHORIZATION OF AVAILABILITY OF EMPLOYEE HEALTH BENEFITS FUND FOR RATE REDUCTION.—Funds in the Employees Health Benefits Fund established under section 8909 of title 5, United States Code, are available without fiscal year limitation for costs incurred by the Office of Personnel Management in making rate reductions provided under this section.

(c) DEFINITION.—For purposes of this section the term "medicare eligible individual" means any annuitant, survivor of an annuitant, or former spouse of an annuitant—

(1) who is—

(A) otherwise eligible for benefits under Chapter 89 of title 5, United States Code;

(B) eligible for benefits under part A of title XVIII of the Social Security Act; and

(C) covered by the insurance program established under part B of such title; and

(2) for whom benefits paid under title XVIII of the Social Security Act are the primary source of health care benefits.

SEC. 423. STUDY AND REPORTS BY THE OFFICE OF PERSONNEL MANAGEMENT ON OFFERING MEDICARE SUPPLEMENTAL PLANS TO FEDERAL MEDICARE ELIGIBLE INDIVIDUALS, AND OTHER CHANGES.

(a) Study and Report.—

(1) No later than April 1, 1989, the Director of the Office of Personnel Management shall conduct a study and submit a report to the Committee on Governmental Affairs of the Senate and the Committee on Post Office and Civil Service of the House of Representatives regarding changes to the health benefits program established under chapter 89 of title 5, United States Code, that may be required to incorporate plans designed specifically for medicare eligible individuals and to improve the efficiency and effectiveness of the program.

(2) Any medicare supplemental plan recommended by the Director of the Office of Personnel Management shall not duplicate benefits for which payment may be made under title XVIII of the Social Security Act, however such recommendation—

(A) shall cover expenses which are not payable under such title by reason of deductibles or coinsurance amounts; and

(B) may offer additional reimbursement—

(i) where benefits under such title are limited by fee schedule; and

(ii) for benefits not covered under such title which may be of value to medicare eligible individuals.

(b) Feasibility Study and Report.—No later than April 1, 1989, the Director of the Office of Personnel Management shall report to the appropriate committees of the Congress whether it is feasible to adopt such standards as issued by the National Association of Insurance commissioners as required by section 1882 of the Social Security Act (42 U.S.C. 1395ss) for medicare supplemental policies, when providing medicare supplemental plans as a type of health benefits plan available for Federal employees pursuant to chapter 89 of title 5, United States Code.

SEC. 424. BENEFITS COUNSELING AND ASSISTANCE DEMONSTRATION PROJECT FOR CERTAIN MEDICARE AND MEDICAID BENEFICIARIES.

(a) Training and Technical Assistance.—

(1) The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project through an agreement with a private or public nonprofit agency or organization, which demonstrates, to the satisfaction of the Secretary, that its volunteers are adequately trained and competent to render effective benefits counseling and assistance to the elderly, for the purpose of providing train-

ing and technical assistance to prepare volunteers to provide to elderly individuals receiving benefits under title XVIII or XIX of the Social Security Act counseling with respect to eligibility for such benefits and assistance in preparing such documentation as may be required to fully receive such benefits.

(2) In addition to any other forms of technical assistance provided under this subsection, the Secretary is authorized to provide to the project—

(A) material to be used in making elderly persons aware of the availability of assistance under volunteer assistance programs under this section; and

(B) technical materials and publications to be used by such volunteers.

(b) Powers of the Secretary.—Under the demonstration project under this section, the Secretary is authorized—

(1) to provide for the training of volunteers, and assist in such training, to insure that volunteers are qualified to provide benefits and counseling assistance (as described in paragraph (1)) to the elderly;

(2) to provide reimbursement to volunteers through the agency or organization for transportation, meals, and other expenses incurred by them in training or providing benefits counseling and assistance under this section, and such other support and assistance as the Secretary determines to be appropriate in carrying out the provisions of this section; and

(3) to provide for the use of services, personnel, and facilities of Federal executive agencies and of State and local public agencies with their consent, with or without reimbursement therefor.

(c) Employment of Volunteers.—

(1) Service as a volunteer in the demonstration project carried out under this section shall not be considered service as an employee of the United States. Volunteers under the project shall not be considered Federal employees and shall not be subject to the provisions of law relating to Federal employment, except that the provisions of section 1905 of title 18, United States Code, shall apply to volunteers as if they were employees of the United States.

(2) Amounts received by volunteers serving in any program carried out under this section as reimbursement for expenses are exempt from taxation under chapters 1 and 21 of the Internal Revenue Code of 1986.

(d) Definition.—For purposes of this section, the term "elderly individual" means an individual who has attained the age of 60 years.

(e) Authorization of Appropriations.—There are authorized to be appropriated, in appropriate parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, for fiscal years 1989, 1990, and 1991 such sums as may be necessary to carry out the provisions of this section.

SEC. 425. CASE MANAGEMENT DEMONSTRATION PROJECTS.

(a) In General.—Within 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in

this section referred to as the "Secretary") shall establish 4 demonstration projects under which an appropriate entity agrees to provide case management services to medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services. At least one such demonstration project shall be conducted through an agreement with a utilization and quality control peer review organization with a contract with the Secretary under part B of title XI of the Social Security Act.

(b) PURPOSE OF PROJECTS.—It is the purpose of the demonstration projects established under this section to provide the Secretary and the Congress with the information necessary—

(1) to evaluate the appropriateness of providing case management services under the medicare program for medicare beneficiaries with high costs of medical care, and

(2) to determine the most effective approach to implementing a case management system under the program for such beneficiaries.

(c) AGREEMENT.—The agreement entered into under subsection (a) shall specify—

(1) the high cost cases with respect to which case management services will be provided under the project,

(2) the payments to be made to the entity conducting the project for carrying out the project, and

(3) such other terms and conditions as the Secretary and the entity conducting the project may agree to.

(d) WAIVERS.—The Secretary shall waive—

(1) such provisions of part B of title XI of the Social Security Act, and

(2) such provisions of title XVIII of such Act as relate to limitations or restrictions on benefits under such title,

as the Secretary determines to be appropriate for the conduct of demonstration projects under this section.

(e) DURATION.—

(1) Except as provided in paragraph (2), a demonstration project under this section shall be conducted for a 2-year period.

(2) The Secretary may terminate a demonstration project before the end of the 2-year period specified in paragraph (1) if the Secretary determines that the entity conducting the project is not in substantial compliance with the terms of the agreement entered into under subsection (a).

(f) INFORMATION AND REPORTS.—

(1) An entity with an agreement under subsection (a) shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of that project.

(2)(A) The Secretary shall submit to the Congress an interim report on the projects conducted under this section based upon information that is derived from the first year of project operations and shall set forth any interim findings, recommendations, and conclusions that the Secretary determines to be appropriate.

(B) The Secretary shall submit to the Congress a final report on the demonstration projects conducted under this section based upon data derived from the projects and shall update the

findings, recommendations, and conclusions set forth in the interim report submitted under paragraph (1).

(g) AUTHORIZATION TO USE CERTAIN FUNDS.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund in such proportions as the Secretary determines to be appropriate, of not to exceed $2,000,000 in each of 2 fiscal years for administrative costs in carrying out the demonstration projects under this section. Such amounts shall be transferred without regard to amounts appropriated in advance in appropriation Acts.

SEC. 426. EXTENSIONS OF EXPIRING PROVISIONS.

(a) HOSPICE WAIVER OF LIABILITY PROVISION.—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "November 1, 1988" and inserting "November 1, 1990".

(b) SKILLED NURSING FACILITY WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9126(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking "30-month", and

(2) by inserting before the period at the end the following: "and ending on October 31, 1990".

(c) HOME HEALTH SERVICES WAIVER OF LIABILITY PRESUMPTION.—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "October 1, 1989" and inserting "November 1, 1990".

(d) HOME HEALTH WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking all that follows "until" and inserting "November 1, 1990.".

(e) PROHIBITION ON NEW COST-SAVING REGULATIONS.—Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) by striking "October 15, 1988" and inserting "October 15, 1989", and

(2) by inserting "or in fiscal year 1990" after "in fiscal year 1989".

SEC. 427. ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS.

(a) ESTABLISHMENT.—The Administrator of the Health Care Financing Administration (in this section referred to as the "Administrator") shall, within 90 days after the date of the enactment of this Act, establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims (in this section referred to as the "Advisory Committee").

(b) MEMBERSHIP.—The Advisory Committee shall be composed of 11 members appointed by the Administrator for the life of the Committee. Of the members appointed—

(1) at least 5 shall be representatives of home health or visiting nurse agencies, and

(2) the remaining members shall be representative of fiscal intermediaries, physician groups, and senior citizen groups, but no more than 3 of such members may be representative of fiscal intermediaries.

Members shall be appointed so as to representative of all geographic areas of the United States.

(c) Duties.—The Advisory Committee shall study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials.

(d) Report.—The Advisory Committee shall report to the Administrator, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, not later than one year after the date of the enactment of this Act, on its study under subsection (c), the findings of its study, and its recommendations for changes in the regulations under title XVIII of the Social Security Act as they relate to denial of claims for home health services.

(e) Miscellaneous Provisions.—

(1) The Advisory Committee shall elect one of its members to serve as Chairman.

(2)(A) A majority of the members of the Advisory Committee shall constitute a quorum for the transaction of business.

(B) The Advisory Committee shall meet at the call of the Chairman, or at the call of a majority of its members.

(3) Members of the Advisory Committee shall serve without compensation, but shall be entitled to reimbusement for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Committee.

(4) The Advisory Committee may appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5, United States Code, governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

(5) In carrying out its duties, the Advisory Committee is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which is has a responsibilty under this section, as the Committee may deem advisable.

(6) The Advisory Committee may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities. Upon request of the Committee, any such department or agency shall furnish any such data or information.

(7) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Advisory Committee may request.

(f) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 428. PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE.

(a) In General.—Part A of title XI is amended by adding at the end the following new section:

"PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE

"SEC. 1140. (a) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

"(1) the words 'Social Security', 'Social Security Account', 'Social Security System', 'Social Security Administration', 'Medicare', 'Health Care Financing Administration', the letters 'SSA' or 'HCFA', or any other combination or variation of such words or letters, or

"(2) a symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 205(c)(2)(E), the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration) or of the Health Care Financing Administration, or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services.

"(b)(1) Subject to paragraph (2), the Secretary may, pursuant to regulations, impose a civil money penalty not to exceed—

"(A) except as provided in subparagraph (B), $5,000, or

"(B) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a).

"(2) The total amount of penalties which may be imposed under paragraph (1) with respect to multiple violations in any one year period consisting of substantially identical communications or productions shall not exceed $100,000.

"(c)(1) Subsections (c), (d), (e), (g), (j), and (k) of section 1128A shall apply with respect to violations under subsection (a) and penalties imposed under subsection (b) in the same manner and to the same extent as such subsections apply with respect to claims in violation of section 1128A and penalties imposed under section 1128A(a).

"(2) Penalties imposed against a person under subsection (b) may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty when finally determined, or the amount

agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.".

(b) AUTHORIZING CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS RELATING TO MEDICAL SUPPLEMENTAL POLICIES.—Section 1882(d) (42 U.S.C. 1395ss(d)) is amended—

(1) by striking "shall be guilty" and all that follows through "or both" in each of paragraphs (1), (2), (3)(A), and (4)(A), and inserting in each case the following: "shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act", and

(2) by adding at the end the following new paragraph:

"(5) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply only with respect to violations occurring on or after such date.

SEC. 429. DEMONSTRATION PROJECTS WITH RESPECT TO CHRONIC VENTILATOR-DEPENDENT UNITS IN HOSPITALS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for up to 5 demonstration projects, for up to 3 years each, to review the appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units. Such projects shall be conducted in consultation with the Prospective Payment Assessment Commission.

(b) WAIVER AUTHORITY.—In conducting demonstration projects under this section for units, the Secretary may treat such a unit as a rehabilitation unit described in section 1886(d)(1)(B) of the Social Security Act for purposes of such section.

And the Senate agree to the same.

From the Committee on Ways and Means, for consideration of titles I, II, and IV of the House bill, and the entire Senate amendment (except for secs. 14, 14A, 14B, 14C, 19, 29, and 25), and modifications committed to conference:

DAN ROSTENKOWSKI,
PETE STARK,
BRIAN J. DONNELLY,
WILLIS D. GRADISON, JR.,

From the Committee on Energy and Commerce, for consideration of titles II, III, and IV of the House bill, and the Senate amendment (except for secs. 2, 3, 12, and 18(a)) and for sec. 6 of the Senate amendment insofar as consideration of such section entails changes in eligibility requirements to participate in part B of the Medicare program, and modifications committed to conference:

John D. Dingell,
Henry A. Waxman,
Ron Wyden,
Edward R. Madigan
(except for sec. 204 of the House bill and sec. 7 of the Senate amendment),

For consideration of sec. 204 of the House bill and sec. 7 of the Senate amendment:

Michael Bilirakis,

From the Committee on Education and Labor, for consideration of sec. 21 of the Senate amendment, and modifications committed to conference:

Gus Hawkins,
William Clay,
James Jeffords,
Managers on the part of the House.

Lloyd Bentsen,
Max Baucus,
Bill Bradley,
George Mitchell,
David Pryor,
John H. Chafee,
John Heinz,
David Durenberger,
Managers on the part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. Short Title; References in Act; Table of Contents (Section 1 of House bill; Section 1 of Senate amendment)

Present law

No provision.

House bill

Specifies that the act may be cited as the "Medicare Catastrophic Protection Act of 1987." Specifies that, except as otherwise specifically provided, whenever an amendment in this act is stated as an amendment or repeal of a section or provision, the reference is to the Social Security Act. Includes a table of contents.

Senate amendment

Similar provision, except specifies that act may be cited as the "Medicare Catastrophic Loss Prevention Act of 1987."

Conference agreement

The conference agreement specifies that the Act may be cited as the Medicare Catastrophic Coverage Act of 1988.

2. Inpatient Hospital Services (Section 101 of House bill; Sections 2 and 3 of Senate amendment)

Present law

(a) Deductible/Spell of Illness.—During each "spell of illness", beneficiaries are required to pay an inpatient hospital deductible ($540 in 1988). A spell of illness is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for 60 days.

(b) Limitation on Covered Inpatient Days.—(1) A beneficiary is entitled to 90 days of inpatient hospital services during each spell of illness. An additional lifetime reserve of 60 days may be drawn upon when an individual exceeds 90 days in a spell of illness. Medicare payment ceases after a beneficiary has used 90 days in a benefit period and exhausted the lifetime reserve days.

(2) The program includes an inpatient psychiatric carryover restriction for persons who are inpatients of a psychiatric hospital on the first day of Medicare entitlement. Days during the immediately preceding 150 days that the individual is an inpatient of a psychiatric hospital are subtracted from the 150 days that would otherwise be available in the initial spell of illness for inpatient psychiatric services.

(c) Coinsurance.—Beneficiaries are liable for daily coinsurance charges, equal to one-quarter of the inpatient hospital deductible for days 61-90 in a spell of illness ($135 in 1988). In addition, beneficiaries are liable for daily coinsurance charges, equal to one-half of the inpatient hospital deductible, for the 60 lifetime reserve days ($270 in 1988).

(d) Part A Premium.—Individuals aged 65 or over who are not automatically entitled to Part A may voluntarily enroll in the program if they pay a monthly premium. The premium amount, updated annually for the following year, is equal to $33 multiplied by the ratio of the inpatient hospital deductible for the following year to the inpatient hospital deductible in 1973.

(e) Adjustment in PPS Payment Rates.—Annual adjustments are made in payment amounts to PPS and PPS-exempt hospitals. Beginning in fiscal year 1988, the Secretary is required to adjust annually hospital weighting factors. Adjustments to outlier cutoff points are made periodically.

House bill

(a) Deductible/Spell of Illness.—Specifies that the deductible is to be applied to the first period of continuous hospitalization that begins in a calendar year. A beneficiary is required to pay only one deductible in a calendar year.

Eliminates "spell of illness" concept.

Specifies that beneficiaries whose "spell of illness" (for which a deductible is imposed) began before January 1, 1988, and had not yet ended as of such date, would not be required to pay an additional deductible for that spell of illness in 1988 or 1989.

(b) Limitation on Covered Inpatient Days.—

(1) Repeals limitations on number of covered inpatient days.

(2) Specifies that the psychiatric carryover restriction applies for the period beginning on the first day of Medicare entitle-

ment and ending at the end of the first period of 60 consecutive days on which the individual is not receiving inpatient psychiatric hospital services. The 150-day limitation is retained.

(c) Coinsurance.—Repeals coinsurance requirements, including, those required for emergency hospital services provided by a hospital that does not participate in Medicare.

(d) Part A Premium.—Requires the Secretary in September of each year (beginning in 1987), to establish the Part A monthly premium amount for the following year equal to the estimated actuarial value of the Part A benefit for such year (rounded to the nearest dollar). The actuarial value equals one-twelfth of the estimated average per capita amount payable from the Federal Hospital Insurance Trust Fund for services and related administrative costs incurred with respect to persons aged 65 and over for Part A benefits for the entire year. The Secretary is required, when the premium amount is promulgated, to issue a public statement setting forth the actuarial assumptions and bases employed in arriving at an adequate actuarial rate.

(e) Adjustment in PPS Payment Rates.—Requires the Secretary (when adjusting payment rates for PPS and non-PPS hospitals, the target amounts, the weighting factors, and the outlier cutoff points), when appropriate, to take into account reductions in beneficiary payments to hospitals resulting from the repeal of the day limitation on inpatient hospital services.

Effective date.—(a) Applies to the deductible for 1988 and succeeding years. (b) and (c) apply to inpatient hospital services furnished on or after January 1, 1988. (d) Applies to premiums for months beginning with January 1, 1988. Conforming amendments effective January 1, 1988. (e) Effective on enactment.

Senate amendment

(a) Deductible/Spell of Illness.—Similar provision, except limited to persons covered under both Part A and Part B. The deductible applies to the first "period of hospitalization" beginning in a calendar year. "Period of hospitalization" is defined as beginning on the first day the individual is furnished inpatient hospital services and ending on the date of discharge from the hospital (or, in the case of a transfer, hospitals) involved.

Eliminates "spell of illness" for persons covered under both Parts A and B.

Specifies that beneficiaries whose period of hospitalization (for which a deductible is imposed) begins during December of a calendar year would not be required to pay an additional deductible for a hospitalization beginning in January of the following year.

(b) Limitation on Covered Inpatient Days.—

(1) Similar provision, except limited to persons covered under both Parts A and B.

(2) Repeals psychiatric carryover restriction for persons covered under both Parts A and B.

(c) Coinsurance.—Similar provision, except limited to persons covered under both Parts A and B. Coinsurance requirements for services furnished outside the United States are also eliminated for these persons.

(d) Part A Premium.—No provision.

(e) Adjustment in PPS Payment Rates.—No provision.

Effective date.—Applies to items and services furnished after December 31, 1987, Beneficiaries (covered under both Parts A and B) whose spell of illness begins before January 1, 1988 and whose period of hospitalization included in that spell of illness begins on or after January 1, 1988 and before February 1, 1988 would not have an inpatient hospital deductible imposed for that period of hospitalization.

(a) *Deductible/Spell of Illness.*—The conference agreement includes the House provision with an amendment. The agreement provides that a beneficiary, whose period of hospitalization (for which a deductible is imposed) begins during December of a calendar year, would not be required to pay an additional deductible for a hospitalization beginning in January of the following year.

The agreement provides that, if the Secretary terminates a contract with a health maintenance organization (HMO) or competitive medical plan (CMP) during a year, no inpatient hospital deductible will be imposed for the remainder of the year on a beneficiary who can demonstrate that he or she, while enrolled in the organization during the year, had an inpatient hospital admission paid for by the HMO or CMP.

(b) *Limitation on Covered Inpatient Days.*—The conference agreement includes the House provision.

(c) *Coinsurance.*—The conference agreement includes the Senate amendment with an amendment deleting the requirement that individuals be enrolled in both Parts A and B.

(d) *Part A Premium.*—The conference agreement includes the House provision with an amendment specifying that the Secretary is first required to establish the monthly premium in September of 1988 which will be in effect for calendar year 1989.

(e) *Adjustment in PPS Payment Rates.*—The conference agreement includes the House provision with an amendment. Under the agreement, the Secretary shall adjust the target amounts for each non-PPS hospital to reflect reductions in beneficiary payments to hospitals resulting from the enactment of this legislation.

(f) *Chronic Ventilator-Dependent Units in Hospitals.*—The conference agreement includes a provision requiring the Secretary to establish up to five demonstration projects for up to three years each to review the appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units. The Secretary is authorized to treat such units as rehabilitation units for reimbursement purposes.

The conferees expect that the Secretary will establish criteria for the demonstration projects which will assure that (1) the units will serve patients who have recently undergone tracheostomy and are newly ventilator-dependent; (2) there is reasonable expectation at admission that the patient will be able to return home or to the community at discharge; (3) the major diagnoses of patients will include spinal cord injury, head trauma, advanced lung disease, Guillain-Barre syndrome, musuclar dystrophy—Duchenne type, polyomyositis and dermatomyositis, and phrenic nerve paralysis secondary to surgical trauma; (4) the rehabilitation programs within the units will include physcial therapy, patient and family instruction in the use of ventilator equipment, self-suctioning and medications, and psychological counseling; (5) expected length of stay within the units will be typically two to four months; and (6) other factors which the Secretary finds relevant.

In establishing the demonstrations the Secretary is required to consult with the Prospective Payment Assessment Commission. In addition, the conferees expect that the Secretary will consult with appropriate professional groups such as the American Thoracic Society and the American College of Chest Physicians.

Effective date.—The Conference agreement applies to the deductible for 1989 and succeeding years. Other provisions apply to care and services occurring on or after January 1, 1989, except that (d) is effective and applies to premiums for January 1989 and succeeding months and (e) is effective for PPS hospital discharges on or after January 1, 1989, and for non-PPS hospitals, for cost reporting periods beginning on or after October 1, 1989.

3. Extended Care Service (Section 102 of House bill; Sections 2 and 3 of Senate amendment)

Present law

(a) Coinsurance.—Beneficiaries are required to pay a daily coinsurance charge (equal to one-eighth of the inpatient hospital deductible) for days 21–100 of post-hospital extended care services furnished during each spell of illness.

(b) Limitation on Covered Days.—The program covers up to 100 days of post-hospital extended care services in a spell of illness.

(c) Prior Hospitalization Requirement.—In order to have payment made for extended care services, the beneficiary must have been an inpatient of a hospital for at least three consecutive calendar days and have been transferred to a participating SNF usually within 30 days. The law has authorized the Secretary to provide coverage for extended care services in a SNF without regard to the 3-day prior hospitalization requirement when he determines that such coverage will not lead to an increase in cost and will not alter the acute nature of the benefit; however, this provision has not been implemented.

House bill

(a) Coinsurance.—

(1) Eliminates current coinsurance requirements. Imposes a daily coinsurance charge for days 1–7 of post-hospital extended care services furnished in a calendar year.

(2) Requires the Secretary, before September 1 of each year (beginning in 1987), to estimate the national average per diem reasonable cost recognized under Part A for post-hospital extended care services which will be furnished in the succeeding calendar year. In September of each calendar year (beginning in 1987) the Secretary is required to promulgate the coinsurance amount for the following year. The amount equals 20 percent (rounded to the nearest $0.50) of the national average per diem reasonable cost estimated by the Secretary. The reference to "post-hospital" is deleted beginning January 1, 1989.

(b) Limitation on Covered Days.—Provides coverage for 150 days of extended care services in a calendar year.

(c) Prior Hospitalization Requirement.—Eliminates prior hospitalization requirement and reference to authority to provide coverage without regard to this requirement.

(d) Spell of Illness.—Repeals spell of illness concept.

Effective date.—Applies to extended care services furnished on or after January 1, 1988, except that elimination of prior hospitalization requirements (and related conforming changes) apply to extended care services furnished pursuant to an admission to a SNF occurring on or after January 1, 1989.

Senate amendment

(a) Coinsurance.—

(1) Similar provision, except limited to persons covered under both Parts A and B. The daily coinsurance charge is imposed on the first 10 days the beneficiary is furnished extended care services during any stay in a skilled nursing facility (SNF), but in no event can a coinsurance amount be imposed for more than 10 days in a calendar year.

(2) Similar provision, except coinsurance equals 15 percent (rounded to the nearest $1.00) of the estimated amount. Eliminates reference to "post-hospital".

(b) Limitation on Covered Days.—Similar provision, except limited to persons covered under both Part A and Part B.

(c) Prior Hospitalization Requirement.—Similar provisions, except limited to persons covered under both Parts A and B.

(d) Spell of Illness.—Similar provisions, except limited to persons covered under Parts A and B.

Effective date.—Applies to extended care services furnished after December 31, 1987. For beneficiaries receiving post-hospital extended care services on December 31, 1987, current law provisions will continue to apply until the spell of illness has ended.

Conference agreement

(a) *Coinsurance.*—The conference agreement includes the House provisions with a modification. The agreement provides that coinsurance charges are to be imposed on the first eight days of extended care services in a calendar year. The amount of the coinsurance is equal to 20% (rounded to the nearest $0.50) of the estimated national average per diem reasonable cost recognized under Part A of Medicare for extended care services.

The agreement extends the current coverage of extended care services in a Christian Science sanatoria from a maximum of 30 days per benefit period to 45 days per calendar year. As under current law, coinsurance would be applied for each day of covered care.

(b) *Limitation on Covered Days.*—The conference agreement includes the Senate amendment with an amendment deleting the requirement that individuals be enrolled in both Parts A and B.

(c) *Prior Hospitalization Requirement.*—The conference agreement includes the House provision.

(d) *Spell of Illness.*—The conference agreement includes the Senate amendment with amendments. The requirement that individuals be enrolled in both Parts A and B is deleted. Beneficiaries whose "spell of illness" began before January 1, 1989, and had not yet ended as of such date, would not be required to pay an additional hospital deductible for that spell of illness in 1989 and 1990.

Effective date.—The conference agreement applies to extended care services furnished on or after January 1, 1989.

4. Hospice Care (Section 103 of House bill; Section 12 of Senate amendment)

Present law

A beneficiary who is terminally ill may elect to receive hospice services for two 90-day periods and one subsequent 30-day period for a total of 210 days during his lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits.

House bill

Provides for a subsequent extension period beyond the current 210-day limit, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program.

Effective date.—Applies to hospice care furnished on or after January 1, 1988.

Senate amendment

Similar provision.

Effective date.—Applies with respect to services furnished on or after date of enactment.

Conference agreement

The conference agreement includes the House provision with an amendment to further extend the favorable presumption under the waiver of liability provision for hospice care through October 1990.

Effective date.—The conference agreement applies to hospice care furnished on or after January 1, 1989.

5. Blood Deductible (Section 104 of House bill; Section 3 of Senate amendment)

Present law

Payment may not be made under Part A for the first 3 pints of whole blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to a beneficiary during a spell of illness. A similar deductible is applied under Part B on a calendar year basis. Under Part B, the deductible (in accordance with regulations) is appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells). For these purposes, blood furnished to an individual is deemed to be replaced when the institution or other person furnishing blood is given one pint of blood for each pint of blood furnished such individual for which the deductible is applicable.

The Part A and Part B blood deductibles are applied separately.

House bill

Specifies that the Part A blood deductible is applied on a calendar year basis. Replacement provisions (identical to those specified for Part (B) are added to Part A. The Part A blood deductible is to be reduced by any blood deductible imposed with respect to Part B.

Specifies that in the case of a beneficiary whose spell of illness begins before January 1, 1988 (and ends after that date), any Part A blood deductible required would be reduced during that spell of illness (during 1988 or 1989) to the extent that a Part A blood deductible had already been imposed for that spell of illness.

Effective date.—Applies to blood or blood cells furnished on or after January 1, 1988.

Senate amendment

Specifies that the Part A blood deductible is to be applied on a calendar year basis for persons covered under both Parts A and B.

Effective date.—Applies to items and services finished after December 31, 1987.

Conference agreement

The conference agreement includes the House provision.

Effective date.—The conference agreement applies to blood or blood cells furnished on or after January 1, 1989.

6. Home Health Benefits (Section 105 of House bill)

Present law

Home health services are covered under Parts A and B. Payments for home health services are always made under Part A except in cases where the beneficiary is enrolled under Part B, but is not entitled to Part A. In these cases, payment is made under Part B.

House bill

Provides that payments for home health services are to be made under Part A only in cases where the individual provided the services is not entitled to Part B in that month. Otherwise, payments are to be made under Part B.

Effective date.—Applies to home health services furnished on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. Imposition of Supplemental Medicare Premium (Section 106 of House bill; Sections 6 and 27 of Senate amendment)

Present law

(a) and (b) In General and Applicability.—The following individuals are eligible for coverage under the Hospital Insurance (Part A) program of Medicare without payment of any premium: (1) those

who have attained age 65 and are eligible for monthly Social Security retirement or survivor benefits, (2) individuals of any age who have been entitled for not less than 24 months to Social Security or Railroad Retirement benefits on the basis of disability (and certain related individuals), (3) individuals of any age who have end-stage renal disease, and (4) certain Federal, State, and local Government employees who have attained age 65. Individuals age 65 or over who are not entitled to Part A benefits because they do not meet the above conditions may enroll in Part A if they pay a monthly premium.

All individuals age 65 and older may elect to enroll in the Supplementary Medical Insurance (Part B) program of Medicare by paying a monthly premium, which is $24.80 in 1988. Individuals who have not attained age 65 but who are eligible for the Part A program by virtue of disability or end-stage renal disease may also elect to enroll in Part B by paying the monthly premium.

(c) Premium Amount.—No provision.

(d) Calculation for Governmental Retirees.—Currently, the pensions of most government retirees are, for the most part, treated as income subject to taxation, while Social Security benefits are tax-exempt unless they exceed a certain threshold (i.e., if adjusted gross income plus 50 percent of the Social Security benefit exceeds $25,000 for individuals, or $32,000 for married couples filing joint returns). These differences in tax treatment of pension income result in larger adjusted gross incomes and tax liabilities for government retirees than for retirees with Social Security.

(e) Premium Indexing.—No provision.

(f) Maximum Supplemental Premium.—No provision.

(g) Joint Returns.—Provides rules for the filing of joint returns for married individuals under section 6013 of the Internal Revenue Code of 1986.

(h) Coordination with Tax Code Provisions.—Section 213 of the Internal Revenue Code of 1986 provides that expenses for medical care (including prescribed drugs or insulin), not compensated for by insurance or otherwise, may be deducted for Federal income tax purposes to the extent that they exceed 7.5 percent of adjusted gross income. Medical care includes insurance payments and Medicare Part B premiums.

House bill

(a) In General.—Amends the Internal Revenue Code of 1986 to impose an annual income-related supplemental premium on Medicare-eligible individuals (generally, those entitled to Part A who file a Federal tax return, except (1) individuals required to pay a premium for Part A coverage, (2) residents of U.S. possessions, and (3) qualified nonresidents) for each taxable year.

(b) Applicability.—Defines a "Medicare-eligible individual" who is liable for payment of the supplemental Medicare premium as an individual who, in any month, is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under Part A of Medicare for such month. Provides for the following exceptions: (1) individuals entitled to Part A benefits solely by reason of the payment of the Part A premium, (2) residents of U.S. commonwealths and territories who pay a special

Part B premium and individuals who are enrolled under Part B but are not entitled to benefits under Part A, and (3) qualified nonresidents.

Defines a "qualified nonresident" as an individual who: (1) is not furnished any service for which payment was or will be made under Medicare Part A during the taxable year or any of the 4 preceding taxable years, (2) is not entitled to benefits under Medicare Part B at any time during the taxable year or any of the 4 preceding taxable years, and (3) is present in a foreign country or countries for at least 330 full days during the 12-month period ending at the close of the taxable year and each of the 4 consecutive preceding 12-month periods. An individual who dies during the taxable year is treated as meeting the 330-day test in that year if the individual spent at least 90 percent of the days before the date of death as full days in a foreign country or countries.

Provides that an individual (other than a nonresident alien) who has attained age 65 will be treated as a Medicare-eligible individual for the month in which he attains age 65 and any subsequent month unless he establishes to the satisfaction of the Secretary that he is not a Medicare-eligible individual for the month concerned.

(c) Premium Amount.—

Provides that for 1988, the premium is as follows:

If the adjusted gross income for the taxable year is:		The annual premium for the taxable year is:
Over:	But not over:	
$0	$6,000	$0
6,000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310

If the adjusted gross income for the taxable year is:		The annual premium for the taxable year is:
Over:	But not over:	
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580

Provides that if an individual is not a Medicare-eligible individual for each month during the taxable year, the annual premium determined from the above table would be prorated based on the number of months an individual is a Medicare-eligible individual during the taxable year. A similar rule applies in the case of a taxable year of less than 12 months, except that the individual's adjusted gross income for the taxable year would be annualized.

(d) Calculation for Governmental Retirees.—No provision.

(e) Premium Indexing.—

(1) In General.—Requires the Secretary of the Treasury, not later than December 15 of 1988 and each subsequent calendar year, to prescribe a table of the supplemental premium amounts which will apply, instead of the 1988 table, with respect to taxable years beginning in the succeeding calendar year.

Requires that each premium dollar amount in the 1988 table be increased by the sum of the Medicare inflation factor and the prescription drug factor for the calendar year, and each other dollar amount in the table (i.e., the bracket amount and the threshold amount) be increased by the cost-of-living adjustment used to index the income tax brackets. If any increase is not a mulitple of $1, it is to be rounded to the nearest multiple of $1.

(2) Catastrophic Coverage Benefit.—Provides that the Medicare inflation factor is the percentage (if any) by which the Medicare value for a calendar year exceeds the Medicare value

for 1988. The Medicare value for any calendar year is the sum for January of such year of (a) 50 percent of the monthly actuarial rate promulgated under section 1818(d)(1) of the Social Security Act for such month (i.e., the Medicare Part A value), and (b) the excess of twice the monthly Part B actuarial rate under section 1839(a)(1) of the Social Security Act, over the amount of the monthly Part B premium under section 1839 (i.e., the Medicare Part B value).

(3) Prescription Drug Benefit.—Provides that the prescription drug factor for 1988 is zero percent, for 1989 is 5.5 percent, and subsequent years is determined as follows: The Secretary of the Treasury in September of each year (beginning with 1989) is required to determine a percent estimated to be necessary so that the total amount of supplemental premiums attributable to the prescription drug factor estimated to be collectible in the next year is equal to 25 percent of the total of the benefits and related administrative costs estimated by the Secretary of HHS under new section 1839(g)(2)(C) of the Social Security Act to be necessary to pay for covered outpatient drugs in the next year.

Requires the Secretary of the Treasury in September of each year (beginning with 1991) to determine whether the amount of the supplemental premium attributable to the prescription drug factor estimated to be collectible (for taxable years beginning in calendar years after 1988 and before the previous calendar year) is greater or less than 25 percent of the total benefits and administrative costs paid for covered outpatent drugs.

If there is a surplus or deficit, the Secretary of the Treasury is required to adjust the prescription drug factor so as to reduce or increase, respectively, the aggregate amount of the additional premiums which are estimated to be collected by the amount of the surplus or deficit, taking into account the effect of any previous adjustments.

Provides that, notwithstanding the adjustment described above, the prescription drug factor for a year after 1990 cannot exceed 120 percent of such factor for the previous year.

(f) Maximum Supplemental Premium.—Provides that the maximum supplemental premium in 1988 is $580. The Joint Committee on Taxation estimates that the maximum supplemental premium in future years would be: for the taxable year beginning in 1989, $737; in 1990, $842; in 1991, $934; and in 1992, $1,017.

(g) Joint Returns.—Provides that in the case of a joint return, the premium amounts according to the table are applied separately to each spouse, and the adjusted gross income of each spouse is one-half of their combined adjusted gross income.

(h) Coordination with Tax Code Provisions.—

(1) Medical Expense Deduction.—Provides that the supplemental premium cannot be treated as a medical expense for purposes of section 213 of the Internal Revenue Code of 1986.

(2) Not Treated as a Tax for Certain Purposes.—Provides that the supplemental premium is not treated as a tax imposed by chapter 1 (income taxes) of the Internal Revenue Code of 1986 for purposes of determining the amount of any credit allowed

under that chapter or the amount of the alternative minimum tax imposed by section 55.

(3) Treated as a Tax for Subtitle F.— Provides that the supplemental premium is treated as if it were an income tax for administrative purposes, such as estimated payments and collection.

(4) Section 15 Not to Apply.—Provides that section 15 (procedures for applying changes in tax rates) does not apply to the supplemental premium.

(i) Reporting Requirements.—Requires the Secretary of HHS to make a return to the Secretary of the Treasury (at such time and in such form as determined by the Secretary of the Treasury) stating the name, address, and taxpayer identification number of each individual entitled to Medicare Part A benefits for any month during the calendar year and the number of months so entitled. The provision does not apply with respect to those who pay a premium under section 1818 for Part A coverage, residents of U.S. commonwealths and territories paying a special Part B premium, and individuals enrolled under Part B but not entitled to benefits under Part A.

(j) Transfer to Trust Funds.—No provision.

Effective date.—Applies to taxable years beginning after December 31, 1987.

Senate amendment

(a) In General.—Amends the Social Security Act to require individuals covered by Medicare Part B to pay an annual income-related supplemental premium if their Federal tax liability for taxable years is not less than $150.

(b) Applicability.—Provides that any individual who is covered by Medicare Part B for any portion of any taxable year occurring after December 31, 1987, and who has Federal income tax liability for such taxable year in an amount not less than $150 must pay the applicable supplemental premium.

(c) Premium Amount.—Provides that the "applicable supplemental premium" equals the number of months in the taxable year during which the individual was covered by Part B, multiplied by the supplemental premium. The "supplemental premium" is defined as the premium rate for the taxable year ($1.09 for the 1988 taxable year), multipled by the amount determined by dividing the individual's adjusted Federal income tax liability for the taxable year by $150.

If the latter amount is not a whole number, it is to be rounded to the next lowest whole number.

(d) Calculation for Governmental Retirees.—For purposes of calculating the supplemental premium, defines "Federal income tax liability" as the tax imposed by chapter 1 (income tax) of the Internal Revenue Code of 1986, reduced by credits allowed under part IV of subchapter A, excluding the following refundable credits: Section 31 (wage withholding for income tax purposes); section 33 (tax withheld at source on nonresident aliens and foreign corporations); and section 34 (certain uses of gasoline and special fuels).

For purposes of calculating the supplemental premium, defines "adjusted Federal income tax liability" as an amount equal to Federal income tax liability, reduced by the following amount. The reduction is the excess (if any) of:

(1) 15 percent of the lesser of (a) the qualified Social Security exclusionary amount, or (b) the amount received as an annuity (whether for a period certain or during 1 or more lives) under a governmental plan which is includible in gross income under section 72 of the Internal Revenue Code of 1986, over

(2) the amount of credit allowed under the tax credit for the elderly and the permanently and totally disabled (section 22 of the Internal Revenue Code of 1986).

Defines "qualified Social Security exclusionary amount" as the excess (if any) of $6,000 ($9,000 in the case of married individuals filing a joint tax return) over the Social Security benefits (as defined in section 86(d) of the Internal Revenue Code of 1986) received during the taxable year. For taxable years beginning after Dec. 31, 1988, the $6,000 and $9,000 amounts are increased from the previous year's amounts by the Social Security cost-of-living adjustment for the calender year in which the taxable year begins.

(e) Premium Indexing.—

(1) In General.—Provides that the premium rate for any taxable year (beginning in a calendar year after 1988) is the previous year's rate, increased or decreased by (a) the premium rate adjustment used to index the monthly catastrophic coverage premium amount in years after 1988, and (b) the drug premium rate adjustment (for taxable years beginning in calendar years after 1989).

(2) Catastrophic Coverage Benefit.—The premium rate adjustment used to update the monthly catastrophic coverage premium amount is:

(a) the percentage (if any) necessary to increase the estimated total revenues collectable from the monthly catastrophic coverage premiums and the supplemental premiums (determined without regard to the drug premium rate adjustment amount) so that they equal the estimated total catastrophic coverage benefits and related administrative costs (including administrative costs for outpatient drug coverage), plus

(b) for calendar years before 1993, the percentage necessary to establish before 1993 a contingency fund equal to 20 percent or, if greater, a reserve fund equal to 5 percent.

(3) Prescription Drug Benefit.—Provides that the drug premium rate adjustment for taxable years beginning in a calendar year after 1989 is an amount equal to:

(a) 50 percent (60 percent for calendar year 1990 and 55 percent for calendar year 1991, as provided in Section 27 of the bill) of the modified per enrollee actuarial catastrophic drug benefit amount for that year plus

(b)(1) for any taxable year beginning in calendar year 1990, an amount necessary to cover 7.5 percent of the modified per enrollee actuarial catastrophic drug benefit amount for 1991, and

(2) for taxable years beginning in calendar years after 1990, an amount (when added to any unexpended amount determined for any preceding year) necessary to cover 7.5

percent of the modified per enrollee actuarial catastrophic drug benefit amount for the calendar year.

Defines "modified per enrollee actuarial catastrophic drug benefit amount" to mean (a) the total catastrophic drug coverage benefits and related administrative costs estimated to be paid in cash outlays from the Federal Catastrophic Drug Insurance Trust Fund divided by the total number of individuals estimated to be enrolled under Part B for the year, or (b) the reestimated per enrollee actuarial catastrophic drug benefit amount that reflects any adjustment the Secretary may make to the drug coverage benefit because the drug benefit premium amount was determined to exceed the premium limit for that year.

(f) Maximum Supplemental Premium.—Provides that the applicable supplemental premium for any individual cannot exceed the number of months in the taxable year the individual was covered by Part B divided by 12, multiplied by the appropriate amount, as follows: for the taxable year beginning in 1988, $800; in 1989, $850; in 1990, $900; in 1991, $950; and in 1992, $1,000.

For taxable years beginning in a calendar year after 1992, the applicable supplemental premium cannot exceed 65 percent of the product of the number of months in the taxable year the individual was covered by Part B, multiplied by the excess of:

(a) the sum of (1) 200 percent of the monthly actuarial basic rate for Part B enrollees age 65 and over (i.e., 200 percent of one-half of the benefit and administrative costs, including a contingency margin, payable for the aged from the Part B trust fund for Part B costs excluding the catastrophic coverage), plus (2) the monthly per enrollee actuarial comprehensive catastrophic benefit amount (i.e., the estimated monthly catastrophic coverage benefits and related administrative costs payable from the Federal Catastrophic Health Insurance Trust Fund divided by the estimated number of Part B enrollees) for the calendar year, over

(b) the sum of the basic and catastrophic monthly premiums for the year, determined without regard to current and new certain hold harmless provisions (which provide limits to any increases in the Part B and catastrophic premiums based on cost-of-living increases in Social Security benefits).

(g) Joint Returns.—Provides that for married individuals (as defined in section 7703 of the Internal Revenue Code of 1986), the supplemental premium is determined by treating such individuals as one individual if they: (1) file a joint return (under section 6013 of such Code) and (2) one or both of them are covered by Part B for any portion of the taxable year and have Federal income tax liability of not less than $150. The number of months of Part B coverage is determined according to the spouse covered for the longer period during the taxable year. When married individuals are treated as one individual in order to calculate the supplemental premium, the limit on such premium equals the sum of the limits computed separately for each spouse.

(h) Coordination With Tax Code Provisions.—

(1) Medical Expense Deduction.—Provides that the supplemental premium is treated as a premium paid under Medicare

Part B in the taxable year following the taxable year to which the premium relates for purposes of section 213(d)(1)(C) of the Internal Revenue Code of 1986.

(2) Not Treated as a Tax for Certain Purposes.—Similar provision.

(3) Treated as a Tax for Subtitle F.—Similar provision.

(4) Section 15 Not to Apply.—Similar provision.

(i) Reporting Requirements.—Requires that the Secretary of HHSA include on the current return to the Secretary of the Treasury relating to Social Security benefits, the number of months any individual is covered under Medicare Part B for the calendar year. Requires the Secretary of HHS to include on the statements sent to Social Security beneficiaries information on the name of the agency making the determination and the number of months of coverage under Medicare Part B.

(j) Transfer to Trust Funds.—Requires the Secretary of the Treasury, from time to time, to transfer from the general fund of the Treasury to the Federal Catastrophic Health Insurance Trust Fund amounts equal to the aggregate monthly supplemental premiums paid (excluding the drug premium rate adjustment), plus the amount the Secretary of the Treasury estimates Federal outlays are reduced under the Medicaid program because of the catastrophic provisions of this bill (after taking into account the provisions of Section 14 of the bill related to Medicaid savings and State requirements). Such transfers are to be appropriately adjusted to the extent that prior transfers were in excess of or less than amounts required to be transferred.

Also requires the Secretary of the Treasury, from time to time, to transfer from the general fund of the Treasury to the Federal Catastrophic Drug Insurance Trust Fund amounts equal to the aggregate drug premium rate adjustment paid, adjusted to the extent that prior transfers were in excess of less than the amounts required to be transferred.

Effective date.—Applies to taxable years ending after December 31, 1987. The supplemental premium rate for any taxable year beginning before 1988 and ending after December 31, 1987, is the rate applicable to 1987.

Conference agreement

(a) *In General.*—Under the conference agreement, medicare Part A eligible individuals are required to pay a new tax-related supplemental premium. The supplemental premium is intended to provide approximately 63 percent of catastrophic coverage and prescription drug benefit financing on a calendar year liability basis, with flat monthly premiums financing the remaining 37 percent (subject to limitations on increases and decreases in the supplemental premium, described below).

The supplemental premium is drafted in the tax Code, collected with income tax payments, and after 1989 subject to income tax estimated payments. Medicare Part A eligible individuals with less than $150 of income tax liability are exempt from the supplemental premium.

To reduce confusion among beneficiaries, the conferees intend that the Secretary of the Treasury is to (1) implement the supplemental premium in an easy to understand manner (including the use of premium tables in lieu of taxpayer calculations, and separate tables as necessary for government retirees), (2) identify the supplemental premium on the applicable forms, worksheets, tables, and instructions as a premium to pay for a portion of the cost of new medicare catastrophic and prescription drug coverage, and (3) seek comments and advice from medicare enrollees and their representatives regarding the design of such forms, worksheets, tables, and instructions.

(b) *Applicability.*—The definition of medicare Part A eligible individuals generally follows the House bill, except that no special proration rule is provided for residents of U.S. commonwealths and territories. Residents of U.S. commonwealths and territories who do not have U.S. income tax liability are not subject to the supplemental premium. An individual is liable for the supplemental premium if such individual is medicare Part A eligible for more than 6 full months during the taxable year and has $150 or more of adjusted U.S. source income tax liability.

Unlike the House bill, individuals who attain the age of 65 during the taxable year are not presumed to be medicare eligible for the purposes of paying the supplemental premium. The conferees intend that the Internal Revenue Service will inform taxpayers that they are liable for the supplemental premium if they are eligible for Part A of Medicare even if they have not actually enrolled.

(c) *Premium Amount.*—For taxable years beginning before 1994, the supplemental premium rate is the sum of the catastrophic coverage and prescription drug premium rates shown below:

SUPPLEMENTAL PREMUIM RATES, 1989–93

[Per $150 of adjusted Federal income tax liability]

	Catastrophic coverage premium rate	Prescription drug premium rate	Total supplemental premium rate
Year in which taxable year begins:			
1989	$22.50	$0	$22.50
1990	27.14	10.36	37.50
1991	30.17	8.83	39.00
1992	30.55	9.95	40.50
1993	29.55	12.45	42.00

The supplemental premium is to be determined under tables (similar to the income tax tables) prescribed by the Secretary of the Treasury which may provide income tax liability brackets of less than $150.

For purposes of computing the supplemental premium, adjusted Federal income tax liability is defined as under the Senate amendment.

The conferees have determined these premium rates to raise sufficient revenue with reference to the tax rates and other important features of the tax Code that determine the liability of the medicare Part A eligible population. The conferees intend that if tax rates or these features are changed in future legislation, the premium rates should be recalibrated.

(d) *Calculation for Government Retirees.*—The Conference agreement generally follows the Senate amendment with changes designed to conform the adjustment for government retirees with the computation of the credit for the elderly and disabled. For government retirees, tax liability is adjusted by subtracting 15 percent of the excess (if any) of (1) the lesser of (i) $6,000 ($9,000 in the case of a joint return where both spouses are medicare eligible for more than 6 full months, and $4,500 for married individuals filing separate returns), or (ii) government annuities includible in gross income during the taxable year, the lower quantity then reduced by social security benefits received during the taxable year; over (2) the credit for the elderly and disabled allowable for the taxable year. After 1989, the $4,500, $6,000 and $9,000 amounts are increased by social security cost-of-living adjustments ("COLAs") determined for calendar years after 1989, and rounded to the nearest multiple of $50.

In the case of a joint return where only one spouse is medicare eligible for more than 6 full months during the taxable year, only government annuities attributable to such spouse are taken into account for purposes of the adjustment for government retirees. In the case of a married individual filing a separate return, such individual shall be treated as receiving not less than half of the social security benefits received by both spouses.

(e) *Premium Indexing.*—(1) *In general.* The method of indexing the supplemental catastrophic coverage and prescription drug premiums was selected by the conferees (1) to assure that premium receipts will be sufficient to pay for all catastrophic coverage and prescription drug benefits (i.e., budget neutrality), and (2) to minimize the Treasury Secretary's discretion over the adjustment of supplemental premium rates.

The indexing formula minimizes discretion by using information on prior year program costs and receipts, rather than subjective projections, and by limiting the amount by which the supplemental premium can be increased in any year.

The indexing machanism seeks to assure budget neutrality by several means: (1) prescription drug outlays may only be made from a new Federal Catastrophic Drug Insurance Trust Fund which is entirely financed by monthly and supplemental prescription drug premiums (and interest on fund balances); (2) monthly and supplemental catastrophic coverage premiums are increased to recoup with interest shortfalls in prior years (monthly premiums are increased to make up for any limitation on the increase in the supplemental premium); and (3) a contingency margin of at lest 20 percent is built into catastrophic coverage and prescription drug premiums.

For taxable years beginning after 1993, the supplemental premium rate is the sum of the adjusted catastrophic coverage premium rate and the adjusted prescription drug premium rate, subject to two limitations. The supplemental premium rate may not (1) be less than the rate in effect for the preceding year; and (2) be more than $1.50 per $150 of tax liability higher than the rate in effect for the preceding year. If either of these two limitations are applicable, the supplemental premium rate is allocated between the catastrophic coverage and prescription drug premium rates in proportion to the respective amounts of these premium rates without regard to the limitations.

(2) *Catastrophic coverage premium.*—The adjusted catastrophic coverage premium rate for any calendar year after 1993 is equal to the rate for the preceding calendar year, without regard to the two limitations on the supplemental premium described above in any prior year, adjusted by a percentage equal to the sum of the outlay-premium and reserve account percentages.

The outlay-premium percentage is designed to index the supplemental catastrophic coverage premium rate by the difference between the projected growth rates of catastrophic coverage outlays and premiums. For years after 1993, the growth in outlays and premiums is projected by a formula which uses data available for the second and third preceding years, plus more recent information on trends in the consumer price index.

The outlay-premium percentage for any calendar year is (1) the percentage change in per capita catastrophic outlays from the third to the second preceding calendar year; minus (2) the percentage change in per capita catastrophic coverage premium liability from the third to the second preceding calendar year (determined as if the supplemental premium rate had not changed from the third to the second preceding year).

The per capita catastrophic outlay for any calendar year, as determined by the Secretary of HHS, is equal to outlays debited from the Medicare Catastrophic Coverage Account (the "Account," see section 17, below) for such year, divided by the average number of individuals entitled to receive Part A benefits during such year.

The per capita catastrophic coverage premium liability for any calendar year, as determined by the Secretary of the Treasury, is equal to supplemental premium liability attributable to the catastrophic coverage premium for taxable years beginning in such year, divided by the number of individuals who had premium liability for taxable years beginning in such year.

The outlay-premium percentage, described above, is adjusted up (or down) by 50 percent of the amount by which the consumer price index ("CPI") inflation rate in the second preceding year exceeds (or is less than) one percentage point.

The CPI inflation rate for any year is defined as the percentage by which the CPI for May of such year exceeds such index for May of the preceding year. The CPI means the last CPI for all-urban consumers published by the Department of Labor, which is most consistent with the CPI for calendar year 1986.

The reserve account percentage is designed to adjust the supplemental catastrophic coverage premium rate to recoup 63 percent of any cumulative shortfall or deficit in the catastrophic coverage program (the other 37 percent is recouped by a corresponding adjustment in the flat premium). For years after 1993, the shortfall or surplus in the catastrophic coverage program is determined from data available for the second proceding year.

The reserve account percentage for any calendar year is the ratio of (1) the change in the catastrophic coverage premium rate for the second preceding year which the Secretary determines would have increased (or decreased) supplemental premium liability for such year by an amount equal to 63 percent of the shortfall (or surplus) in the Account in such year, over (2) the catastrophic coverage premium rate for the preceding calendar year, without regard to the two limitations on the supplemental premium described above.

The shortfall (or surplus) in the Account for any calendar year is determined as (1) 20 percent of catastrophic outlays debited against the Account; minus (2) the Account balance at the end of such year (including flat and supplemental premium increase amounts attributable to reserve account percentages in prior years that have not yet been credited to the account.

(3) *Prescription Drug Premium.*—The adjusted prescription drug premium rate for any calendar year after 1993 is equal to the rate for the preceding calendar year, without regard to the two limitations, described above, which may have applied to the supplemental premium for any prior year, adjusted by a percentage determined in a manner similar to the catastrophic coverage premium, with the following changes: (1) in determining the premium-outlay percentage, prescription drug outlays rather than catastrophic outlays are used; (2) in determining the reserve account percentage, the Federal Catastrophic Drug Insurance Trust Fund balance (see section 16, below) is used rather than the Account balance; (3) the reserve account percentage is 75 percent for 1994, 50 percent for 1995, and 25 percent for 1996 and 1997, instead of 20 percent; and (4) the outlay-premium percentage is deemed to be zero for calendar years before 1998.

For calendar years after 1992 the following procedure is to be followed for announcing supplemental premium rate changes. The Secretary of the Treasury shall: (1) not later than July 1, announce the preliminary increase in the supplemental premium for the following year; and (2) not later than October 1, announce the actual supplemental premium rates for the following year. (For additional detail see sections 16 and 17, below).

(f) *Maximum Supplemental Premium.*—For taxable years beginning before 1994, the maximum supplemental premium for an individual filing a single return is $800 in 1989, $850 in 1990, $900 in 1991, $950 in 1992, and $1050 in 1993.

For calendar years after 1993, the maximum supplemental premium is equal to such maximum in the preceding year (before rounding) increased by the percentage (if any) by which the medicare-part B value for the second preceding year exceeds such value for the third preceding year. The maximum supplemental premium is rounded to the nearest multiple of $50. The conferees designed the formula to maintain the miximum supplemental premium as a constant fraction of the value of Part B benefits not paid for by monthly premiums.

The midicare-part B value for any calendar year is defined as the excess of per capita Part B outlays the year over 12 times the generally applicable monthly Part B premium for months in such calendar year. Per capita Part B outlays are outlays from Part B of title XVIII of the Social Security Act divided by the average number of individuals covered under such part during the year. In computing the maximum supplemental premium for years before 1988, the medicare-Part B value is computed by excluding outlays and monthly premiums for covered outpatient drugs.

(g) *Joint and Separate Returns.*—(1) *Joint returns.*—In the case of a joint return where both spouses are medicare Part A eligible for more than 6 full months during the taxable year, such spouses are treated as a single individual, except that the maximum supplemental premium is twice the amount that applies for single returns.

In the case of a joint return where only one spouse is medicare eligible for more than 6 full months during the taxable year, income tax liability for the medicare-eligible spouse is determined as one-half of the tax liability of the joint return.

(2) *Separate Returns.*—In the case of a married individual filing a separate return who did not live apart from his or her spouse at all times during the taxable year, such individual is treated as medicare Part A eligible for 6 full months during the taxable year if the individual or the individual's spouse was so eligible. In addition, the maximum supplemental premium is twice the amount that applies for single returns if, without regard to this provision, both spouses are Medicare Part A eligible for 6 full months during the taxable year.

These rules are intended to prevent the supplemental premium from creating an incentive for separate filing.

(h) *Coordination with Tax Code Provisions.*—(1) *Medical expense deduction.*—As under the House bill, the supplemental premium is not deductible as an itemized medical expense.

(2) *Not treated as a tax for certain purposes.*—As under the House bill and the Senate amendment, the supplemental premium is not treated as an income tax for purposes of determining the amount of any tax credit or the amount of the alternative minimum tax. Revenues from the supplemental premium are not covered over to any possession of the United States, and the supplemental premium is not automatically reflected in the tax laws of territories that "mirror" the U.S. tax Code. In the case of a taxable years of less than 12 months, the supplemental premium shall be applied under regulations prescribed by the Secretary.

(3) *Treated as a Tax for Subtitle F.*—The supplemental premium generally is treated as if it were an income tax for administrative purposes, such as estimated payment and collection. The conference agreement provides that estimated tax penalties do not apply with respect to supplemental premium liability for taxable years beginning in 1989. The conferees intend that the Internal Revenue Service will where appropriate exercise its discretion to provide relief from estimated tax penalties in the first year in which an individual becomes liable for the supplemental premium (similar relief already is provided for newly retired or disabled individuals in sec. 6654(e)(3)(B)).

(4) *Section 15 not to Apply.*—The supplemental premium is not treated as a change in income tax rate.

(i) *Reporting Requirements.*—The Secretary of HHS shall include in the existing return to the Secretary of the Treasury relating to social security benefits, a determination of whether any individual was medicare Part A eligible for more than 6 full months during the year. The Secretary of HHS is to include the same information on the statements sent to social security and railroad retirement beneficiaries, as well as the name of the agency which determines medicare eligibility.

The Secretary of HHS may provide such additional information to the Secretary of the Treasury as is required to assure compliance with the supplemental premium.

(j) *Transfer to Trust Funds.*—Receipts attributable to the supplemental prescription drug premium rate are appropriated to the CDI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the CDI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maxmium supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

Receipts attributable to the supplemental catastrophic coverage premium rate, which are not otherwise appropriated to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (the "Reserve Fund") are appropriated to the SMI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the SMI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

Effective date.—The supplemental premium is effective for taxable years beginning after December 31, 1988.

8. Delay in Organ Procurement Requirements (Section 26 of Senate amendment)

Present law

The Omnibus Budget Reconciliation Act of 1986 provided that Medicare payments for organ procurement would not be made unless: (a) the organ procurement agency involved met specified requirements and was designated by the Secretary as the sole procurement agency in its service area, and (b) hospitals establish protocols for making a routine inquiry for organ donation by potential donors, and are members of the National Organ Procurement and Transplantation Network.

Under the Omnibus Budget Reconciliation Act of 1986, these provisions were to be effective as of October 1, 1987. The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 changed this effective date to November 21, 1987. The Omnibus Budget Reconciliation Act of 1987 extends the effective date for item (a) to March 31, 1988.

House bill

No provision.

Senate amendment

Extends to December 31, 1988, the date by which the Secretary must complete the organ procurement agency designation process, the effective date of the requirements for hospital protocols for organ procurement, and the effective date for requiring hospitals to be members of the National Organ Procurement Network.

Effective date.—Enactment.

Conference agreement

The conference agreement does not include the Senate provision. The conferees note that a related provision was included in the Omnibus Budget Reconciliation Act of 1987.

9. Limitation on Medicare Out-of-Pocket Expenses (Section 201 of House bill; Sections 4 and 29 of Senate amendment)

Present law

Under current law, beneficiaries are liable for specified cost-sharing charges, in form of deductibles and coinsurance amounts, in connection with their use of inpatient hospital, skilled nursing facility, and hospice services, and blood under Part A.

Beneficiaries enrolling in Part B are required to pay a monthly premium. The program generally pays 80 percent of the reasonable charge for physicians and other covered medical services (including immunosuppressive drugs furnished within one year of a covered organ transplant) after the beneficiary has met the $75 deductible. The beneficiary is liable for the remaining 20 percent of the reasonable charge (coinsurance). In addition, where a physician does not accept assignment (i.e., does not agree to accept Medicare's determination of reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge and the physician's actual charge (the "balance billed amount"). The beneficiary is also liable for a separate Part B deductible.

There is no upper limit on the amount of cost-sharing charges beneficiaries are required to pay in connection with covered Medicare services.

House bill

(a) In General.—Establishes an annual limit on beneficiary out-of-pocket expenses (not including balance billed amounts) for covered part B services.

(b) Payment When Limit Has Been Reached.—Provides that if an individual has incurred out-of-pocket Part B expenses in a calendar year (beginning in 1989) equal to the Part B catastrophic limit for that year, the program will pay 100 percent of Part B reasonable charges (or costs) for covered Part B services (including physicians' services, ambulatory surgical center services, and dialysis services). In addition, after the beneficiary has reached the limit, no further blood deductible is required.

(c) Expenses Counting Toward the Catastrophic Limit.—Specifies that the following beneficiary expenses count toward the catastrophic limit:

(1) the Part B deductible, and blood deductible;

(2) Part B coinsurance charges; and

(3) a maximum of $250 in covered outpatient mental health expenses.

(d) Catastrophic Limit.—Specifies that the Part B catastrophic limit for 1989 is $1,043. The limit for any succeeding year is the limit for the preceding year increased by the Social Security cost-of-living adjustment (COLA), rounded to the nearest dollar. The Secretary is required to promulgate the Part B catastrophic limit by November 15 of each year (beginning with 1988) that will be in effect for the following year.

(e) Payments to Prepaid Health Plans Paid on a Reasonable Cost Basis.—Requires the Secretary to provide for an appropriate adjustment to payment rates for prepaid health plans paid on a reasonable cost basis to reflect the new catastrophic protection. The adjustment is to reflect: (1) the aggregate increase in payments which would otherwise be made for enrollees if they were not enrolled in the organization; or (2) the amount that would be paid to the organization or a facility if payments were made on an individual by individual basis. The organization is required to provide assurances, satisfactory to the Secretary, that it will not undertake to charge an individual during a year for covered services after the individual has reached the catastrophic limit (whether through the organization facility, or otherwise). [See Item 19(b)]

(f) Limitation on Charges When Catastrophic Limit Reached.—Specifies that providers (i.e., hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, or hospice programs) with agreements with the Medicare program may not charge beneficiaries for services for which catastrophic benefit payments are made to the provider.

(g) Notice for Beneficiaries Reaching Catastrophic Limit.—Requires Medicare carriers to provide individuals, who have incurred sufficient out-of-pocket expenses, to qualify for catastrophic benefits, with a notice in a form appropriate for presentation to a physician. The notice is to: (1) state that the individual has reached the Part B catastrophic limit for the year; and (2) encourage the physician not to charge the individual amounts in excess of Medicare's reasonable charge and to accept payment on an assignment related basis for the remainder of the year.

(h) No provision.

Effective date.—Enactment (applies to items and services furnished after December 31, 1988).

Senate amendment

(a) In General.—Establishes an annual limit on beneficiary out-of-pocket expenses (not including balance billed amounts) for covered Part A and B services and entitles a Part B beneficiary to have payment made to him or on his behalf for specific catastrophic medical expenses.

(b) Payment When Limit Has Been Reached.—Provides for payment of 100 percent of catastrophic medical expenses. "Catastrophic medical expenses" are defined with respect to an individual for a calendar year (beginning with 1988) as any beneficiary cost sharing amounts incurred by an individual after the individual has in-

curred specific out-of-pocket medical expenses equal to the catastrophic limit. The program will pay beneficiary cost sharing amounts for: (1) the hospital deductible, SNF coinsurance charges, hospice coinsurance charges, and the Part A blood deductible; (2) the Part B deductible and Part B blood deductible; and (3) Part B coinsurance charges.

(c) Expenses Counting Toward the Catastrophic Limit.—Specifies that the following beneficiary expenses count toward the catastrophic limit:

(1) the Part A hospital deductible, SNF coinsurance charges, hospice coinsurance charges, and blood deductible;

(2) the Part B deductible and blood deductible;

(3) Part B coinsurance charges;

(4) amounts expended for qualified services for the prevention of illness or injury. A service meets this definition if:

(A) The service is one of the following: glaucoma screening by tonometry, cholesterol screening, a "Pap" test for detecting breast cancer, an immunization or booster for tetanus, influenza, or bacterial pneumonia, an occult blood stool test, or tuberculosis sensitivity testing;

(B) The service has not been provided to the beneficiary in the preceding 12 months; and

(C) The service is provided incident to a comprehensive physical which is performed by a physician, which includes a full history and other specified components, and which meets such other requirements as the Secretary may prescribe, including requirements to ensure a comprehensive approach for preventive health services.

Requires the Secretary to establish guidelines for the described preventive services no later than January 1, 1989.

(d) Catastrophic Limit.—Specifies that the Medicare catastrophic limit is $1,850 for 1988 and $2,030 for 1989. The limit for any succeeding year is the limit for the preceding year increased by the percentage, as determined by the Secretary, which will ensure that the percentage of Part B eligibles (other than those enrolled in HMOs or CMPs) whose out-of-pocket costs are projected to exceed the limit during that year will be the same as the percentage whose costs exceeded the limit in 1989. The Secretary is required to promulgate the limit by November 15 of each year (beginning with 1987) that will be in effect for the following year.

(e) Payments to Prepaid Health Plans Paid on a Reasonable Cost Basis.—Similar provision. Adjustments in payment rates are also applicable for renal dialysis facilities. Assurances to the Secretary specify that the organization or facility will not charge the individual during a year for any catastrophic medical expense incurred during that year.

(f) Limitation on Charges When Catastrophic Limit is Reached.—Similar provision.

(g) Notice for Beneficiaries Reaching Catastrophic Limit.—No provision.

(h) Beneficiary Costs of Catastrophic Insurance.—

(1) Findings.—States that the Senate finds that: (A) Medicare catastrophic insurance will provide beneficiaries with important and far-reaching protection, greatly reducing out-of-pocket

liability for those who incur high medical expenses; (B) the new benefits will be financed through premiums collected from all beneficiaries; (C) the Department has announced that the Part B premium will increase by 38.5 percent in January, 1988; (D) Medicare beneficiaries already are liable for Medicare premiums equal to 2.9 percent of their median income; and (E) it is the responsibility of Congress to ensure that the additional premiums for catastrophic coverage do not reach such levels as to unreasonably increase the out-of-pocket liability of Medicare beneficiaries.

(2) *Sense of the Senate.*—Expresses that it is the sense of the Senate that conferees take all necessary steps to ensure that cost controls on new benefits, particularly coverage of prescription drugs, are sufficient to protect program integrity, prevent escalation of costs, and reduce amounts required for premium financing. In addition, it is the sense of the Senate that Senate conferees be instructed to take all feasible steps to minimize beneficiary costs by keeping premiums at the lowest possible level, ensuring that year-to-year premium increases are gradual and predictable, ensuring that the income related premiums do not unduly burden middle-income older Americans, and ensuring that the combined basic and supplemental premiums do not exceed the value of the program to beneficiaries.

Effective date.—(a)-(g) Applies to items and services furnished after December 31, 1987. In determining whether an individual has incurred out-of-pocket medical expenses in 1988 equal to the catastrophic limit, only expenses incurred on or after July 1, 1988, are taken into account. (h) Effective on enactment.

Conference agreement

(a) *In General.*—The conference agreement includes the House provision with an amendment.

(b) *Payment When Limit Has Been Reached.*—The conference agreement includes the House provision.

(c) *Expenses Counting Toward the Catastrophic Limit.*—The conference agreement includes the Senate amendment with a modification. The agreement does not include expenses for Part A cost-sharing, or for preventive services in the calculation of expenses counting toward the catastrophic limit.

The conference agreement, in section 204, provides coverage of screening mammography (including associated professional and technical services) effective January 1, 1990, subject to frequency limitations, quality standards, and special payment rules.

The agreement provides coverage for a biennial screening mammography for women aged 65 and over. For disabled women under age 65, a baseline screening would be available between age 35 and 40. Between ages 40 and 49, screenings would be available every other year, except that screenings could be provided each year for high risk women. Between ages 50 and 64 screenings could be provided on an annual basis.

The agreement requires the Secretary, in consultation with the Director of the National Cancer Institute, to review periodically the appropriate frequency for performing screening mammographies, based on age or other factors. The Secretary, on the basis of this review, may revise the frequency for covered screenings performed on or after January 1, 1992.

The agreement requires the Secretary to establish standards to assure the safety and accuracy of screening mammographies. The standards must include the following requirements: (i) the equipment used must be specifically designed for mammography and must meet radiologic standards established by the Secretary; (ii) the screening must be performed by an individual who is either licensed by the State to perform radiologic procedures or is certified as qualified to perform such procedures by an appropriate organization recognized by the Secretary; (iii) the results of the mammography must be interpreted by a physician who either is certified by the American Board of Radiology or is otherwise certified by a program recognized by the Secretary by regulation as assuring that the physician is qualified to interpret the results of screening mammography; and (iv) there must be assurances that the results of the first screening paid for by Medicare will be placed in permanent medical records maintained for the woman.

The conferees understand that a bilateral four-view procedure is currently considered to be the standard of care in the United States for screening mammography. The conferees therefore anticipate that this would be initially included in the quality standards to be developed by the Secretary as a requirement for coverage, subject to change with new technology and additional medical information. The conferees also note that the reimbursement level provided for under this provision is premised on the understanding that a four-view procedure would be provided.

State survey and certification agencies and private accreditation programs (if approved) could be used to verify compliance with required quality standards.

Payment would be 80% of the least of: (i) the actual charge, (ii) the fee schedule allownce (with respect to both the professional and technical components of screening mammography) established under Section 1834(b) of the Social Security Act, or (iii) a reasonable charge limit. The limit would be $50 in 1990 and would be indexed thereafter by the percent increase in the Medicare Economic Index (MEI).

Beginning January 1, 1992, the Secretary may reduce the reasonable charge limit, as it applies nationally or in an area, if the Secretary finds such action both appropriate and consistent with maintaining convenient access for beneficiaries to screening services.

The agreement provides for an appropriate allocation of the reasonable charge limit between professional and technical components in the case of hospital outpatient screening mammographies (and comparable situations) where there is a claim for professional services separate from the claim for associated technical services. In these cases, payment for the technical component would be based on the allocated reasonable charge limit.

The agreement sets maximum allowable actual charge (MAAC) limits for screening mammographies performed by nonparticipating physicians. These MAAC limits are based on the fee schedule established for radiologists under Section 1834(b) of the Act.

The MAAC limits are 125% of the reasonable charge limit in 1990, 120% of the reasonable charge limit in 1991, and 115% of the reasonable charge limit in 1991 and subsequent years. The Secretary is empowered to impose sanctions against physicians or suppliers who knowingly and willfully impose charges in excess of the limits.

The MAAC limits would be in effect until such time as the Secretary implements a fee schedule for physicians' services based on the relative value scale mandated under Section 1845(e) of the Social Security Act.

The conferees are aware of concern that the $50 reasonable charge limit might limit the availability of mammography in physicians' offices even though the procedure may be available at clinics, hospital outpatient departments, and outpatient radiology facilities. Accordingly, the conference agreement requires the Physician Payment Review Commission to study the cost of providing screening mammography in a variety of settings and at different volume levels. The report would be submitted to Congress by July 1, 1990.

Finally, the conference agreement requires GAO to conduct a study of the quality of screening mammography provided in clinics, hospital outpatient departments, and outpatient radiology facilities as compared with physician offices. This report would also be due by July 1, 1990.

(d) *Catastrophic Limit.*—The conference agreement includes the Senate amendment with a modification. The agreement sets the Part B catastrophic limit for 1990 at $1370. The agreement requires the Secretary to set the limit for future years at an amount necessary to ensure that the percentage of Part B enrollees (not including enrollees in health maintenance organizations) whose expenses are expected to exceed the cap during that year is 7 percent.

The conference agreement requires the Secretary to promulgate, not later than September 1 of each year (beginning in 1990), the catastrophic limit which will be in effect for the following calendar year.

(e) *Payments to Prepaid Health Plans Paid on a Reasonable Cost Basis.*—The conference agreement includes the House provision, with amendments. The provisions relating to charges for covered services after an individual has reached the catastrophic limit apply to organizations with a risksharing contract, as well as to those paid on a reasonable cost basis. Different rules apply depending on whether the organization does or does not "buy out" Part B deductible and coinsurance charges for enrolled beneficiaries. A plan is deemed to be a buy-out plan if the actuarial value of the coinsurance and deductible charges it imposes on enrollees for Part B services (other than for outpatient drugs) is less than 50 percent of the national average actuarial value of the Part B coinsurance and deductible for all Medicare beneficiaries.

In the case of a buy-out plan, actual cost-sharing amounts for Part B services incurred by a beneficiary while enrolled in the plan are not counted towards the catastrophic limit. However, the enrollee is deemed to have incurred Part B cost-sharing expenses for each month of enrollment equal to the monthly national average actuarial value of Part B deductible and coinsurance amounts.

In the case of a plan than is not a buy-out plan, cost-sharing amounts for Part B services incurred by a beneficiary while enrolled in the plan are counted towards the catastrophic limit. The plan may not enter into a Medicare contract or receive Medicare payment unless it provides assurance satisfactory to the Secretary that: (i) it will maintain, in coordination with the appropriate Part B carriers, accounts of Part B cost-sharing expenses incurred by enrollees during each year, including out-of-plan services; (ii) it will make the accounts available to an enrollee and to the carrier if an enrollee disenrolls during the year (or at any time, in the case of an organization paid under section 1833); and (iii) it will not undertake to charge any enrollee for Part B services (other than outpatient drugs) after the enrollee has incurred cost-sharing expenses, whether through the organization or otherwise, equal to the catastrophic limit for the year.

The conferees expect that the Secretary, in establishing contracts with Part B carriers under section 1842, will require the carriers to provide information on expenses for out-of-plan services to the plans without charge.

If a beneficiary is enrolled in a plan which has its contract terminated by the Secretary during a year, no inpatient hospital deductible will be imposed on an individual who can demonstrate to the satisfaction of the Secretary that he or she was admitted to a hospital during the calendar year.

(f) *Limitation on Charges When Catastrophic Limit Reached.*—The conference agreement includes the Senate amendment.

(g) *Notice for Beneficiaries Reaching Catastrophic Limit.*—The conference agreement includes the House provision with a modification. The required notice is to state that the individual has reached the Part B catastrophic limit for the year.

(h) *Beneficiary Costs of Catastrophic Insurance.*—The conference agreement does not include the Senate amendment. The amendment expressed the sense of the Senate, and was duly passed by the Senate.

Effective date.—The conference agreement applies to items and services furnished on and after January 1, 1990.

10. Coverage of Catastrophic Expenses for Prescription Drugs (Section 202 of House bill; Sections 11 and 28 of Senate amendment)

Present law

Medicare generally does not cover outpatient prescription drugs which can be self-administered by the patient. The program covers under Part B immunosuppressive drugs which are furnished within one year of an organ transplant covered by Medicare.

House bill

(a) In General.—Adds "covered outpatient drugs" to services included within the definition of "medical and other health services". Defines a "covered outpatient drug" as one that is: (1) approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, or, in the case of a drug which is a biological product, is licensed under the Public Health Service Act; and (2) insulin certi-

fied under the Federal Food, Drug, and Cosmetic Act. The term does not include any drug or insulin provided to an inpatient as part of inpatient hospital services, extended care services, or incident to physicians' services. The term does not include immunosuppressive drugs which are furnished within 1 year of a covered organ transplant.

(b) Phase-In Coverage.—No provision.

(c) Deductible.—

(1) Provides that expenses for covered outpatient drugs do not count toward the Part B deductible and that the Part B deductible is not applicable for covered outpatient drugs.

(2) Requires the individual, before the program makes payments for covered outpatient drugs, to establish that he has incurred (or has had paid in his behalf) expenses for covered outpatient drugs during the year equal to the drug deductible. The Secretary is required, upon application by the individual, to promptly notify the individual (and, if submitted by or through a participating pharmacy, the pharmacy) as to whether he has met the deductible.

(3) Sets the deductible at $500 in 1989. The increase in 1990 and 1991 is equal to the increase in the medical care component of the consumer price index (for the 1-year period ending the previous August). In future years, it is increased by the percentage increase in the outpatient prescription drug index established by the Secretary. The base point of the index is the prices of covered outpatient drugs as of August 1990. In September of each year (beginning in 1991), the Secretary is to determine the percentage change for the preceding 12 months (rounded to the nearest dollar). The Secretary is required to publish the deductible each year beginning in 1989.

(d) Adjustment in Deductible.—Provides for an adjustment if the Secretary's estimate of the additional Part B premium needed to finance the drug benefit indicates an increase of more than 20 percent over the previous year. In this case, the Secretary would increase the deductible by an amount sufficient to reduce the costs of the program to the level that would be financed by a 20 percent premium increase. (The premium is to cover 75 percent of total costs of the drug benefit; see Item 15.)

(e) Authority to Reduce Deductible—No provision.

(f) Payment Amount.—

(1) Specifies that, subject to the deductible, the amount paid with respect to a covered outpatient drug is equal to lesser of the actual charge or the applicable payment limit minus 20 percent of the actual charge. The payment amounts are also applicable for payments for immunosuppressive drugs during the first year following a covered organ transplant.

(2) Specifies that the payment calculation periods are the 6-month periods beginning with January and July of each year.

(3) Requires the Secretary, (before each 6-month payment calculation period beginning on or after January 1, 1989), to provide information on payment limits to participating pharmacies and groups representing or assisting beneficiaries.

(4) Requires the Secretary to provide for an appropriate adjustment to payment rates for prepaid health plans paid on a

reasonable cost basis to reflect the new catastrophic drug benefit. The adjustment is to reflect: (A) the aggregate increase in payments which would otherwise be made for enrollees if they were not enrolled in the organization; or (B) the amount that would be paid to the organization or a facility if payments were made on an individual by individual basis. The organization is required to provide assurances, satisfactory to the Secretary, that it will not undertake to charge an individual more than 20 percent of the reasonable cost plus any amount needed to satisfy the deductible.

(g) Payment Limits for Non-Multiple Source Drugs and Drugs With Restrictive Prescriptions.—

(1) Provides that the payment limit for a drug which is either not a multiple source drug or a multiple source drug with a restrictive prescription is the sum of: (A) the product of the number of dosage units or tablet units and the average per tablet or unit wholesale price; plus (B) an administrative allowance.

(2) Requires the Secretary to determine (with respect to dispensing a covered outpatient drug in a payment calculation period beginning on or after January 1, 1989) the average per tablet or unit wholesale price based on the average wholesale price for purchases in reasonable quantities. The determination is to be based on wholesale prices for the first day of the third month before the beginning of the payment calculation period. The determination and calculation of the payment limits are to be made on a national basis, except that the determination and calculation may be done on a regional basis to take into account limitations in availability or variations in average wholesale prices for a drug product.

(3) Specifies that a drug has a restrictive prescription only if the prescription indicates, in the handwriting of the physician (or other person prescribing the drug), and with an appropriate phrase recognized by the Secretary, that the particular drug must be dispensed. An appropriate phrase may be "brand medically necessary)."

(h) Payment Limit for Multiple Source Drugs Without Restrictive Prescriptions.—

(1) Provides that the payment limit for a multiple source drug without a restrictive prescription is the sum of: (A) the product of the number of tablets or dosage units and the unit limit, plus (B) the administrative allowance. Specifies that the unit limit is 50 percent of the brand name reference price for the reference drug product for the period.

(2) Requires the Secretary to establish a brand name reference price for each reference drug product for each payment calculation period. For the 6-month period beginning January 1, 1987, the brand name reference price for a drug product is the average per tablet or unit wholesale price (based on purchases of reasonable quantities) as of January 1, 1987.

Specifies that for each subsequent 6-month payment calculation period, the reference price is increased by the increase in the consumer price index (for the 6-month period ending in the third month of the previous calculation period).

Specifies that for a reference drug product which was not available on January 1, 1987, the base period is the first month of the first payment calculation period in which it is available.

Specifies that brand name reference prices are to be established on a national basis, except that the prices may be established on a regional basis to take into account limitations in availability or variations in the average wholesale price for a drug product.

(3) Defines a multiple source drug as a covered outpatient drug for which (during the payment calculation period) there are 2 or more drug products which: (A) are rated thereapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products With Therapeutic Equivalence Evaluations" which is available on the first day of the third month before the beginning of the period; and (B) are sold or marketed during the period.

Specifies that a drug is considered as sold or marketed if it listed in the FDA publication unless the Secretary determines that the sale or marketing is not actually taking place.

(4) Defines a "reference drug period" as a multiple source drug in reference to which other drug products are rated as therapeutically equivalent in the FDA publication.

(i) Administrative Allowance.—Specifies that the administrative allowance is $4.50 for drugs dispensed in a payment calculation period beginning in 1989. For each subsequent payment calculation period, the administrative allowance is increased by the percentage increase (if any) in the implicit price deflator for gross national product.

(j) Assuring Appropriate Utilization.—

(1) Provides that the Secretary may provide that payment for covered outpatient drugs may not be made if they are prescribed or dispensed with excessive frequency or in excessive quantities. The Secretary is required to establish a utilization review program for covered outpatient drugs to identify instances of unnecessary or inappropriate prescribing or dispensing practices and to identify quality of care problems.

(2) No provision.

(k) Treatment of Certain Prepaid Organizations.—Establishes rules with respect to prepaid organizations which do not impose charges on covered outpatient drugs. For purposes of the drug provision, the actual charges of the organization are the organization's standard charges to members and other persons not entitled to drug benefits. The standard charges are to be used for purposes of the drug deductible.

(l) Physician Guide.—Requires the Secretary to develop, and update annually an information guide for physicians on the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient prescription drugs. To the extent practicable, the guide is to group drugs in a manner useful to physicians by therapeutic category or conditions for which they are prescribed. The guide is to specify the wholesale prices on the basis of the amount required for a typical daily therapeutic regimen. The Secretary is required to mail the guide by March 1 of each year (beginning in 1989) to each hospital with a provider

agreement with Medicare and each physician who routinely provides Medicare services.

(m) Special Cost-control Measures.—No provision. See Item 10(d) on adjustment in deductible for requirement that Secretary increase drug benefit deductible to prevent excessive increase in premiums.

(n) High Volume Pharmacies.—No provision.

(o) Report on Payment Limits.—Requires the Secretary to review the payment limits established for covered outpatient drugs and report to Congress by April 1, 1989, on the appropriateness of the limits, together with any recommendations for change.

(p) Report on Covered Outpatient Drug Index.—Requires the Secretary to report to Congress by January 1, 1991, on the covered outpatient drug index.

(q) Participating Pharmacies.—

(1) Defines a participating pharmacy as one which is authorized under State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary. Under the agreement, the entity agrees:

(A) Not to refuse to dispense covered outpatient drug items, stocked by the entity, to Medicare Part B beneficiaries and not to charge them more for such drugs than charged to the general public;

(B) To keep patient records (including records on expenses incurred by beneficiaries) for all covered outpatient drugs dispensed to beneficiaries;

(C) To assist beneficiaries in determining whether they have met the drug deductible including providing the necessary documentation;

(D) To provide, upon request of a beneficiary, a copy of his records to another participating pharmacy or Medicare carrier;

(E) To offer to counsel or offer to provide information to each beneficiary on the appropriate use of a dispensed drug and whether there are potential interactions between this drug and others dispensed to the beneficiary;

(F) To advise the beneficiary on the availability (consistent with State drug substitution laws) of therapeutically equivalent covered outpatient prescription drugs; and

(G) To submit, effective January 1, 1992, all claims requests electronically, except this requirement may be waived by the Secretary in cases of undue hardship.

Pharmacies operated by prepaid organizations for the exclusive benefit of its members are not required to dispense covered outpatient drugs to nonmembers.

(2) Requires the Secretary to provide each participating pharmacy with a distinctive emblem and, before each payment calculation period, information on payment limits established under the drug benefit.

(3) Requires the Secretary to provide for periodic audits of participating pharmacies to insure that they do not impose charges on beneficiaries in excess of those charged to the general public.

(4) Payments for covered outpatient drugs may only be made on an assignment basis in the case of participating pharmacies.

(r) Civil Monetary Penalty.—No provision.

(s) Limitation to 60 Day Prescription.—Prohibits Part B payments for covered outpatient drugs if dispensed in excess of a 60-day supply.

(t) Additional Premium for Prescription Drug Benefit.—Refers to section 106(a) of the bill. (See Item 15.)

(u) Use of Carriers in Administration.—

(1) Requires carriers making determinations or payments with respect to covered outpatient drugs to: (A) offer to receive payment requests electronically; and (B) respond to requests by participating pharmacies as to whether an individual has met the deductible. The Secretary may enter into agreements for processing of drug claims on a regional basis.

(2) No provision.

(v) Modification of HMO/CMP Provisions.—

(1) Requires HMOs and CMPs with Medicare risk sharing contracts to take into account drug expenses incurred in a year by individuals who enroll after January 1 of a year.

(2) No provision.

(3) No provision.

(w) Medicaid Requirements.—See Item 33.

(x) Beneficiary Drug Cost Survey and CBO Report.—

(1) Requires the Secretary to conduct a statistically valid survey, and report to Congress by March 1, 1989, on expenses incurred by beneficiaries for covered outpatient drugs. The Secretary is required to consult with the General Accounting Office (GAO) and the Congressional Budget Office (CBO) concerning survey design. The survey is to provide information on the distribution of expenses for covered outpatient drugs for Medicare beneficiaries generally and the distribution of expenses by age, sex, income, and institutional status.

(2) Requires the CBO (within 2 months of submission of the report) to estimate Medicare expenditures for fiscal year 1990-93 for covered outpatient drugs.

(3) No provision.

(y) Prescription Drug Payment Review Commission.—Requires the Director of the Office of Technology Assessment (OTA) to provide for the appointment of a Prescription Drug Payment Review Commission to be composed of individuals with expertise in the provision and financing of covered outpatient prescription drugs. The Director of OTA shall appoint the 11 Commission members by October 1, 1988, for staggered 3-year terms. The membership must include recognized experts in health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as one Medicare beneficary. The Commission is required to make annual recommendations to the Secretary.

(z) Additional Studies.—

(1) Requires the Secretary to conduct studies on:

(A) Extent of private or other third-party drug coverage for beneficiaries;

(B) Comparison of published average wholesale price and actual pharmacy acquisition costs by type of pharmacy;

(C) Overhead costs of retail pharmacies;

(D) Potential application of new claims processing and billing technologies;

(E) Methods for utilization review;

(F) Alternative payment methodologies that promote greater program efficiencies; and

(G) Potential for induced demand resulting from the drug benefit.

(2) Requires the Secretary, as part of the studies, to conduct a longitudinal study on the use of covered outpatient drugs by beneficiaries with respect to medical necessity, potential for adverse drug interactions, and patient stockpiling or wastage. The Secretary is required to report to Congress on the results of the studies by January 1, 1991.

(3) No provision.

(aa) Study of Treatment of Prescription Drugs.—No provision.

(bb) Simplification of Recordkeeping.—No provision.

Effective date.—Applies to drugs dispensed on or after January 1, 1989. (u) and (y) effective on enactment. (v) applies to new enrollments effected on or after January 1, 1989.

Senate amendment

(a) In General.—Adds "covered outpatient drugs" to services included within the definition of "medical and other health services". Defines a covered outpatient drug as one which is: (1) approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, or is recognized in the "United States Pharmacopoeia" (and is available only under a prescription); or (2) in the case of a prescription drug which is a biological product, is licensed under the Public Health Service Act. The term does not include any drug or biological which would have been paid for under Medicare prior to enactment of this law. The term does not include immunosuppressive drugs which are furnished during the first year following a covered transplant.

(b) Phase-In Coverage.—

(1) Specifies that in 1990, the term covered outpatient drug includes a drug which is an intraveneously administered anti-infective agent, a cancer chemotherapeutic agent (including a drug used to enhance the safety and efficacy or counteract the toxicity of anticancer drugs) or immunosuppressive drugs after the first year following a covered organ transplant.

(2) Specifies that in 1991 and 1992, the term covered outpatient drug includes drugs specified under item (1) and any cardiovascular or diuretic drug.

(c) Deductible.—

(1) Similar provision.

(2) Identical provision.

(3) Sets the deductible at $600 in 1990. In subsequent years, it is increased by the percentage by which the Part B beneficiary drug expenditure amount for the 12-month period ending the previous August exceeds such amount for the preceding 12 months (rounded to the nearest dollar). [See Item 15 below for definition of beneficiary drug expenditure amount.] The Secre-

tary is required to publish each September (beginning in 1990) the deductible for the following year.

(d) Adjustment in Deductible.—No provision.

(e) Authority to Reduce Deductible.—Provides that if the Secretary determines there is sufficient revenue to pay all of the benefits and administrative costs, and to provide an adequate contingency margin (as determined by the Secretary), the Secretary may reduce the deductible amount to $500 in 1991, $400 in 1992, and $300 in 1993.

(f) Payment Amount.—

(1) Similar provision, except specifies that the applicable payment limit is subject to reductions applied to high volume pharmacies.

(2) Specifies that the payment calculation period is the 12-month period beginning every January (after 1989).

(3) Similar provision except: (A) applies to payment calculation periods beginning on or after January 1, 1990; and (B) also requires provision of information on any reductions applied for high volume pharmacies.

(4) Permits a prepaid health plan paid on a reasonable cost basis to elect to be paid 80 percent of the reasonable cost of immunosuppressive and covered outpatient drugs. Such organization may not charge individuals more than 20 percent of the reasonable cost plus any amount needed to satisfy the deductible.

(g) Payment Limits for Non-Multiple Source Drugs and Drugs With Restrictive Prescriptions.—

(1) Similar provision.

(2) Similar provision except: (A) applies to determinations for payment calculation periods beginning on or after January 1, 1990; (B) specifies that the average per tablet or unit wholesale price is the most recently published figure; and (C) requires the calculation to be made on a national basis if the drug is available on a national basis.

(3) Similar provision, except applies to written prescriptions. Specifies that for telephone prescriptions, the physician or other person (through the use of an appropriate phrase) states that the particular drug must be dispensed.

(h) Payment Limit for Multiple Source Drugs Without Restrictive Prescriptions.—

(1) Provides that the payment limit for a multiple source drug without a restrictive prescription is the sum of (A) the product of the number of tablets (or other dosage units) and 150 percent of the lowest average per tablet or unit wholesale price for the drug; and (B) the administrative allowance.

(2) Requires the Secretary to determine with respect to covered outpatient drugs for the payment calculation period (beginning on or after January 1, 1990) the average per tablet or per unit wholesale price for the drug for purchases in reasonable quantities. Specifies that for the period beginning January 1, 1987, the average is the average per tablet or per unit wholesale price for the drug as of January 1, 1987.

Specifies that for subsequent payment calculation periods, the amount is the lesser of: (A) the most recently published average per tablet or per unit wholesale price; or (B) the average per tablet or unit price established for the previous payment calculation period increased by the percentage change in the Consumer Price Index for the 12-month period ending the preceding August.

Requires the Secretary to establish the average per tablet or per unit wholesale price, in the case of a covered outpatient drug which is not available as of January 1, 1987, for the first month of the first payment calculation period in which it is available.

Requires the Secretary to make determinations on a national basis if the drug is available on a national basis. If not, the Secretary may make determinations and calculate payment limits on a regional basis to take into account the availability of drug products and variations in average wholesale prices.

(3) Defines a multiple source drug as a covered outpatient drug for which (during the payment calculation period), there are 2 or more drug products (or in the case of a covered outpatient drug subject to a patent, 3 or more drug products) generally available to beneficiaries through retail pharmacies which the Secretary determines are: (A) pharmaceutically equivalent, bioequivalent, adequately labeled, and manufactured in compliance with the Current Good Manufacturing Practice regulations; and (B) sold or marketed during the period.

Specifies that drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity. Drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or if they do present such a problem, are shown to meet an appropriate bioequivalence standard.

Specifies that a drug is considered to be sold or marketed during a period if it is listed in the Food and Drug Administration's most recent publication of "Approved Drug Products With Therapeutic Equivalance Evaluations" for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

(4) No provision.

(i) Administrative Allowance.—Similar provision, except: (A) administrative allowance is $3.50 for nonparticipating pharmacies for the payment calculation period beginning January 1, 1990; and (B) the amounts are increased annually rather than biannually.

(j) Assuring Appropriate Utilization.—

(1) Provides that the Secretary may provide that payment for covered outpatient drugs may not be made in specific instances if they are prescribed or dispensed with excessive frequency or in excessive quantities. The Secretary is required to establish a utilization review program for covered outpatient drugs to identify patterns of unnecessary or inappropriate prescribing or dispensing practices, including excessive charging in the dispensing of drugs and to identify patterns of substandard care.

(2) Requires the Secretary in carrying out the utilization review program, to use diagnosis and indication codes and establish standards for the prescribing, dispensing, and utilization for each covered outpatient drug. In establishing the standards, the Secretary (after providing notice in the Federal Register and not less than a 60-day comment period) may incorporate standards from current authoritative medical references as he may select.

(k) Treatment of Certain Prepaid Organizations.—Identical provision.

(l) Physician Guide.—Similar provision, except guide must be mailed by January 1 of each year (beginning in 1990).

(m) Special Cost-Control Measures.—Requires the Secretary to institute necessary cost control measures if he determines that the monthly catastrophic drug benefit premium will exceed the limits established under this bill. (See Item 15.) In carrying out this provision, the Secretary may not exclude from coverage or limit payment for any specific covered outpatient drug or specific class of covered outpatient drugs or change the methodology for calculating whether the individual has met the deductible. However, the Secretary may exclude from coverage all drugs listed in a major classification of the most recently issued version of Veterans' Administration Medication Classification System.

(n) High Volume Pharmacies.—Authorizes the Secretary, after 1990, to reduce by regulation the payment limits established (both for nonmultiple source and multiple source drugs) dispensed by a high volume pharmacy (as defined by the Secretary). The reductions are to be based on differences between high volume pharmacies and other pharmacies with respect to operating costs, quantity discounts, and other economies. The Secretary is required to consult with high volume pharmacists, elderly groups and private insurers in making such adjustments. A minimum 90-day public comment period is required for proposed regulations.

(o) Report on Payment Limits.—Requires the OTA and the Secretary to submit to the Congress before beginning of the calendar year (for years after 1990) recommendations for adjustments to the payment limits. The Secretary is required to request the National Academy of Sciences, acting through the Institute of Medicine, to enter into a contract to make such recommendations. Each is required to consult with pharmacists, pharmaceutical manufacturers, elderly groups, and private insurers in making such recommendations.

(p) Report on Covered Outpatient Drug Index.—No provision.

(q) Participating Pharmacies.—

(1) Similar provision except:

(A) Does not apply in the case of any entity which dispenses covered outpatient drugs exclusively to beneficiaries enrolled in HMOs and CMPs;

(B) Identical provision;

(C) To assist beneficiaries in determining whether or not their expenses for covered outpatient drugs exceed the deductible and to certify to the Secretary, with respect to such beneficiaries that their expenses exceed the deductible and make available supporting documentation. Nothing is to be construed as authorizing the Secretary to require submission of the documentation with respect to prescriptions other than pursuant to an audit, upon certification under this provision, or for monitoring purposes from a sample of up to 7.5 percent of participating pharmacies;

(D) Identical provision;

(E) Specifies that the provision of information to beneficiaries is to be consistent with State law respecting the provision of such information;

(F) Identical provision;

(G) Changes the effective date to January 1, 1991.

(2) Identical provision.

(3) Identical provision.

(4) Identical provision.

(r) Civil Monetary Penalty.—Provides that civil monetary penalties may be imposed in the case of participating or nonparticipating pharmacy which presents, or causes to be presented, a request for payment for covered outpatient drugs at a charge greater than that charged the general public.

(s) Limitation to 60 Day Prescription.—Similar provision except permits up to a 90 day supply in the case of an individual receiving chronic maintenance drug therapy as defined by the Secretary.

(t) Additional Premium for Prescription Drug Benefit.—No specific cross reference (See Item 15).

(u) Use of Carriers in Administration.—

(1) Similar provision, except includes fiscal intermediaries in title.

(2) Specifies that 95 percent of clean claims for covered outpatient drugs are to be paid within 45 days of receipt.

Specifies that contracts with carriers shall provide that no payment shall be issued, mailed, or otherwise transmitted for covered outpatient drugs within 30 days after the claim is received.

(3) Authorizes the Secretary to enter into contracts with intermediaries and carriers for performance of functions relating to home intravenous drug therapy on a regional basis.

(v) Modification of HMO/CMP Provisions.—

(1) Identical provision.

(2) Specifies that the calculation of the premium rate and the actuarial value of the deductible and coinsurance for individuals enrolled only in Part A or Part B is to be made separately for the drug benefit.

(3) Specifies that additional benefits required to be provided by an HMO/CMP may include reduction of premium rate or other charges made with respect to drugs.

(w) Medicaid Requirements.—See Item 33.

(x) Beneficiary Drug Cost Survey and CBO Report.—

(1) Similar provision, except requires the Secretary also to consult with consumer groups and representatives of the pharmaceutical and pharmacist industries. Report on survey due by January 19, 1989.

(2) Identical provision.

(3) Requires the GAO (within 2 months of submission of the report) to report on the validity of the survey and the extent to

which pharmacies accept assignment and barriers, if any, to such acceptance.

(y) Prescription Drug Payment Review Commission.—No provision.

(z) Additional Studies.—

(1) Similar provision, except does not include Item B. Adds study requirement on the possibility of including drugs which have not yet been approved under the Federal Food, Drug, and Cosmetic Act, but which are commonly used in the treatment of cancer or immunosuppressive therapy as covered outpatient drugs. The study shall be conducted in consultation with an advisory board of consumers, experts in the field of cancer therapy and immunosuppressive therapy, representatives of pharmaceutical manufacturers, and such other individuals as the Secretary may select.

(2) Similar provision except requires an interim report by not later than January 1989.

(3) Requires the Secretary and the GAO to each conduct and periodically update a study on comparison of published average wholesale prices and actual pharmacy acquisition costs by type of pharmacy. A report is to be sumitted to Congress on the results of each study and update with the first report due no later than January 1, 1989.

(aa) Study of Treatment of Prescription Drugs.—

(1) Requires the OTA to conduct a study to identify additional or alternative covered outpatient drugs that can be included under the Medicare definition for 1991 and 1992.

(2) Requires the Secretary to request the National Academy of Sciences, through the Institute of Medicine, to enter into a contract under which the Institute, in consultation with representatives of appropriate research and health care organizations, will also conduct the study described in (1). The Secretary is to be responsible for related expenses incurred by the Academy.

Specifies that in conducting the study, the Office and the Institute are to give particular attention to those drugs that meet any or all of the following criteria:

(A) The drug is used by a large number of beneficiaries;

(B) The drug can be covered without significant administrative difficulties;

(C) Coverage will provide useful information with respect to utilization and cost of covered outpatient drugs under Medicare;

(D) Coverage will not cause an unreasonble increase in premiums under Medicare;

(E) The drug is expensive when used as part of a chronic drug regimen.

Requires the OTA and the Institute to submit to the Secretary and appropriate congressional committees an interim report within 6 months of enactment, and a final report containing specific findings and recommendations within 12 months.

(bb) Simplification of Recordkeeping.—Requires the Secretary, by October 1, 1988, to enter into an agreement with two or more pri-

vate entities to conduct demonstration projects to test the use of magnetic cards, electronic billing, and other technological devices in the administration of the drug benefit.

Specifies that the Secretary shall select among applications submitted by entities in the form prescribed by the Secretary. The Secretary shall determine the time necessary to carry out the project and submit a report within 6 months of completion.

Specifies that the projects are to be conducted at statistically relevant locations and be used for providing quick data for projecting total cost of the drug benefit.

Requires the Secretary to develop, in consultation with representatives of participating pharmacies, consumers, and other interested individuals, a standard receipt to be used by Medicare beneficiaries in making purchases from participating pharmacies. The receipt is to be distributed by January 1, 1990. The Secretary is to take appropriate steps to insure that such pharmacies used the receipt.

Effective date.—Enactment.

Conference agreement

(a) *In General.*—The conference agreement includes the House provision with an amendment. The agreement includes coverage for two additional categories of prescription drugs. The first category includes those drugs (i) which were commercially used or sold prior to the Drug Amendments of 1962 and (ii) which are identical, similar or related to those described in clause (i) provided that the Secretary has not made a final determination that the drugs described in clause (i) or (ii) are "new drugs." These drugs are the so-called "pre-1938" drugs and are not subject to current requirements regarding pre-market approval by the Food and Drug Administration (FDA) for safety and efficacy.

The conference agreement also includes coverage for certain so-called DESI drugs. Under the provisions of the 1962 amendments to the Federal Food, Drug, and Cosmetic Act, all new drugs must be shown to be effective and safe rather than just safe as had been required previously. This legislation also applied retroactively to all drugs approved as safe from 1938 to 1962. The program established to review the effectiveness of these drugs was named the Drug Efficacy Study Implementation (DESI) program. Under the program, drugs were labelled effective, probably effective, possibly effective, or ineffective. The FDA reviewed any additional evidence submitted by the manufacturer for those drugs determined to be less than effective. If the FDA decides that a drug product lacks substantial evidence of effectiveness for the conditions it is intended to treat, it publishes a notice of opportunity for hearing in the Federal Register on a proposal to withdraw approval for marketing. This affords the manufacturer an opportunity for a hearing before a final determination is made. The conference agreement includes coverage for DESI drugs for which the Secretary has not issued a notice for an opportunity for a hearing and for which the Secretary has determined there is compelling justification for its medical need. Also included are identical, similar or related drugs. It is the understanding of the conferees that the only DESI drug which would be covered by this provision, because a notice for an opportunity for a hearing has not been issued, is nitroglycerin patches.

The agreement further clarifies that the term "covered outpatient drugs" does not include drugs which are already being reimbursed under current law because they are provided as part of, or incident, to other covered services.

(b) *Phase-in Coverage.*—The conference agreement includes the Senate amendment with modifications. The agreement provides coverage for two categories of drugs in 1990—drugs used in immunosuppressive therapy and covered home intravenous (IV) drugs.

Drugs used in immunosuppressive therapy are currently covered for only one year after a transplant that is covered by Medicare. The conference agreement would retain this coverage, which would remain subject to current rules on coinsurance. The conference agreement would add subsequent coverage as well, irrespective of whether the transplant was covered by Medicare. This subsequent coverage would be subject to the same rules regarding deductible and coinsurance as apply to other newly covered prescription drugs.

The agreement provides for coverage of all "covered outpatient prescription drugs" effective January 1, 1991. The agreement provides for a phase-in of the benefit by reducing the requisite beneficiary coinsurance over a three-year period.

Coinsurance is set at 50% in FY 1990 and FY 1991, 40% in FY 1992, and 20% in FY 1993 and each year thereafter. The agreement limits coinsurance to 20%, starting in 1990 with no phase-in, for home IV drugs and immunosuppressive drugs used during the first year after a Medicare covered transplant. (For subsequent use of immunosuppressive drugs, coinsurance would be determined by the general rule.)

The agreement defines a covered home IV drug as one that is intravenously administered in a home setting. The term includes antibiotic drugs, unless the Secretary has determined, for a specific drug or for the indication for which it is applied, that it cannot generally be safely or effectively administered in a home setting. The term includes additional IV drugs (other than antibiotics) only if the Secretary determines that for the specific drug and the indication for which it is being applied, that it can generally be administered safely and effectively in a home setting. The Secretary could establish guidelines or precautions necessary to assure the safety and effectiveness of specific IV drugs in a home setting.

The agreement does not require the Secretary to consult with an advisory panel in making these determinations. The conferees note that the Secretary could refer review of safety and effectiveness issues to the Public Health Service's Office of Health Technology Assessment.

The conferees expect that the Secretary will complete a review of the safety and effectiveness of home IV cancer chemotherapy drugs as soon as possible.

A drug, which would otherwise be covered as an outpatient drug, is excluded from coverage if the drug is intravenously administered in a home setting and does not satisfy the definition of a covered home IV drug.

(c) *Deductible.*—

(1) The conference agreement includes the Senate amendment.

(2) The conference agreement includes the House provision. In determining whether a beneficiary has met the deductible, the Secretary would count all expenses paid on behalf of the beneficiary, such as those paid pursuant to an insurance policy. In calculating the deductible, the Secretary must include amounts actually paid by the beneficiary (or on the beneficiary's behalf) and may not reduce such amounts by applying Medicare payment screens below the deductible.

(3) The conference agreement includes the Senate amendment with a modification. The agreement sets the deductible at $550 in 1990, $600 in 1991, and $652 in 1992. In future years the deductible will be indexed so as to ensure that the percentage of Part B enrollees (not including enrollees in health maintenance organizations) whose expenses for covered outpatient drugs are expected to exceed the deductible during that year is 16.8%. This is the same percentage as the percentage of enrollees whose costs are expected to exceed the deductible in 1991. The conference agreement specifies a deductible for 1992 in the law rather than relying on indexing by the Secretary, because actual program data necessary for reliable indexation would not be available in time for setting the 1992 deductible.

The agreement requires the Secretary to publish by May 1 of each year (beginning in 1992) a proposed regulation establishing the deductible for the next year. The Secretary would be required to publish a final regulation during the last 3 days of September. The final deductible established in September may not exceed deductible proposed in May.

The conference agreement provides that the drug deductible will not apply for home IV drugs dispensed as part of a continuous course of therapy initiated while the beneficiary was a hospital inpatient. Further, the drug deductible does not apply with respect to immunosuppressive drugs furnished within one year following a covered organ transplant.

(d) *Adjustment in Deductible.*—The conference agreement does not include the House provision.

(e) *Authority To Reduce Deductible.*—The conference agreement does not include the Senate amendment. Because the deductible after 1992 will be indexed to ensure that 16.8% of beneficiaries reach the deductible, the Secretary would be authorized to lower or raise the deductible.

(f) *Payment Amount.*—

(1) The conference agreement includes the Senate amendment with a modification. The agreement specifies that the amount paid for a covered outpatient drug is equal to the "payment percent" multiplied by the lesser of the actual charge or the applicable payment limit. The payment percent is 100% minus the required coinsurance. Thus, in 1990 (and thereafter), the payment percent is 80% for home IV drugs and for immunosuppressive drugs used during the first year post transplant. The payment percent for other covered outpatient drugs is 50% in 1990 and 1991, 60% in 1992, and 80% thereafter.

The agreement deletes the reference to high volume pharmacies.

(2) The conference agreement includes the House provision with an amendment specifying that the first payment calculation period begins January 1, 1990.

(3) The conference agreement deletes the Senate amendment requiring that the information on payment limits be provided on a list sent to pharmacies. The conferees note, however, that this information will be available through the electronic system. The reference to high volume pharmacies also is deleted.

(4) The conference agreement includes the Senate amendment, with modifications. The provisions relating to charges for covered services after an individual has met the catastrophic deductible for outpatient drugs apply to organizations with a risk-sharing contract and those paid on a reasonable cost basis as well as to those health care prepayment plans that have elected to provide the catastrophic drug benefit. Different rules apply depending on whether the organization does or does not "buy out" drug charges below the catastrophic deductible amount for enrolled beneficiaries. A plan is deemed to be a buy-out plan if the deductible charge it imposes on enrolles for covered outpatient drugs is less than 50 percent of the Medicare catastrophic deductible for outpatient drugs.

In the case of a buy-out plan, actual expenses for outpatient drugs incurred by a beneficiary while enrolled in the plan are not counted towards the catastrophic limit. However, if an enrollee disenrolls during a year, he or she is deemed to have incurred expenses for covered drugs during each month of enrollment during the year equal to the monthly national average drug expenses during that year for all Medicare beneficiaries. The Secretary is required, in December of each year, to estimate the national average expense for covered drugs for the following year.

In the case of a plan that is not a buy-out plan, expenses for covered outpatient drugs incurred by a beneficiary while enrolled in the plan are counted towards the catastrophic limit. The plan may not enter into a Medicare contract or receive Medicare payment unless it provides assurances satisfactory to the Secretary that: (i) it will maintain, in coordination with the Part B carriers, accounts of expenses for covered drugs incurred by or on behalf of enrollees during each year, and will make the accounts available to an enrollee and to the carrier if an enrollee disenrolls during the year; and (ii) in determining whether an enrollee has met any deductible under its own plan, the organization will take into account all those expenses for covered drugs that are to be counted towards the catastrophic drug deductible.

The conferees expected that the Secretary, in establishing contracts with Part B carriers under section 1842, will require the carriers to provide information on expenses for out-of-plan services to the plans without charge.

(g) *Payment Limits for Non-Multiple Source Drugs and Multiple Source Drugs With Restrictive Prescriptions.—*

(1) The conference agreement includes the House provision with a modification. The Medicare payment limit for a single

source drug or a multiple source drugs with a restrictive prescription is the lessor of:

(A) the 90th percentile of actual charges for the drug adjusted (as appropriate by the Secretary) to reflect the number of dosage units or tablet units dispensed; or

(B) the administrative allowance plus the number of tablets or dosage units dispensed times the per tablet or per unit average wholesale price. The agreement specifies that the 90th percentile limit would be computed on a statewide, carrier-wide or other appropriate geographic area basis (as determined by the Secretary) using charge data from the second previous payment calculation period. The 90th percentile limit would not be used before January 1, 1992 because the necessary data would not be available.

(2) The conference agreement includes the House provision with an amendment. The agreement requires the Secretary to conduct a biannual survey of a representative sample of direct sellers, wholesalers, or pharmacists (as appropriate) to determine the applicable average wholesale price or comparable direct price for each single source drug as of the first day of the first month of the previous payment calculation period. The Secretary would be prohibited from taking into account any discounts that might be provided by wholesalers or direct sellers to pharmacies in determining the applicable average wholesale or direct prices.

Because the survey is a necessary part of the drug benefit and is vital to ensuring the integrity of reimbursement limits, the conference agreement permits the Secretary to impose civil money penalties of up to $10,000 if a wholesaler or direct seller refuses, after a request by the Secretary, to provide information required for the survey or provides information that is false. The conference agreement also requires pharmacies to cooperate with the survey and provides penalties for non-compliance. (*See* subparagraph (g), below.) Information gathered pursuant to the survey would be confidential and could not be disclosed by the Secretary, except as the Secretary determines to be necessary to administer the drug benefit.

The Secretary would not be required to conduct a survey with respect to a specific drug if the Secretary determines that such a survey would not be appropriate because of low volume of sales or other appropriate reason. The survey requirement could also be waived for covered outpatient drugs dispensed during 1990. In these circumstances, the Secretary would rely on published average wholesale prices from reliable sources and would have the authority to set the average wholesale price on the basis of the lowest reliable published price.

The agreement specifies that the Secretary shall make the determination of the average wholesale price based on the price or prices of purchases in reasonable quantities. The Secretary is further required to make the determinations and calculate the payment limit on a national basis. However, the Secretary could make such determinations on a regional basis to take into account limitations on the availability of drug products and variations in average wholesale prices among regions.

(3) The conference agreement includes the Senate amendment with an amendment. In the case of telephone prescriptions, a drug would only be subject to a restrictive prescription if the physician (or other person) through use of an appropriate phrase (as required for written prescriptions) states that a particular brand must be dispensed and submits a written confirmation to the pharmacy involved within thirty days after the date of the telephone prescription. If such confirmation is not submitted, payment would be based on limits for the corresponding multiple source drug.

(h) *Payment Limit For Multiple Source Drugs Without Restrictive Prescriptions.*—

(1) The conference agreement includes the Senate amendment with an amendment. The payment limit for a multiple source drug without a restrictive prescription is the sum of: (A) the product of the number of dosage units or tablet units dispensed and the unweighted median of the per unit average wholesale prices of the available drug products plus (B) an administrative allowance.

To determine the median, the Secretary would array the average wholesale prices (by appropriate dosage or tablet unit) for all FDA approved drug products that are rated by the FDA as therapeutically equivalent, including the corresponding brand name drug. (*See* subparagraph (3), below.

(2) The conference agreement includes the Senate amendment with a modification. In calculating the unweighted median, the Secretary is generally expected to use the average wholesale price for multiple source drugs based on reliable published sources. However, where appropriate, the Secretary may conduct a biannual survey of average wholesale prices of specific multiple source drugs. Such a survey is comparable to (and could be conducted in conjunction with) the annual survey of such prices for single source drugs. The conferees intend that the Secretary may exclude a drug from the calculation of the median if it is not being actively marketed.

(3) The conference agreement includes the House provision with an amendment. The agreement provides that in order for drugs to be multiple source drugs, the FDA must determine that they are pharmaceutically equivalent and bioequivalent as defined by the Medicare statute. This definition is the same as that currently used by the FDA. The agreement assumes that such FDA determination would be made at the time FDA approves the drug; it does not require a new or subsequent determination.

If the FDA changes the definition of therapeutic equivalence through a formal rule-making procedure (including a 90 day comment period), the requirement of pharmaceutical equivalence and bioequivalence as contained in the Medicare statute would not apply and the drug would only be required to meet the revised FDA definition of therapeutic equivalence.

(4) The conference agreement does not include the House provision.

(i) *Administrative Allowance.*—The conference agreement includes the Senate amendment with an amendment setting the administrative allowance for participating pharmacies at $4.50 in 1990 and 1991 and for nonparticipating pharmacies at $2.50 in 1990 and 1991. Thereafter, the allowances are indexed by the GNP price deflator.

(J) *Assuring Appropriate Utilization.*—

(1) The conference agreement includes the Senate amendment with modifications. The agreement does not include the provision authorizing the Secretary to deny payment for drugs prescribed or dispensed with excessive frequency or in excessive quantities. The conferees note that such new authority is unnecessary. The Secretary already has authority under Section 1862(a)(1) of the Social Security Act to deny payment for items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. Pursuant to this authority, the Secretary could deny payment for drugs prescribed or dispensed with excessive frequency or in excessive quantities.

The conference agreement requires the Secretary to establish a program to identify: (i) instances and patterns of unnecessary or inappropriate prescribing or dispensing practices; (ii) instances or patterns of substandard care; and (iii) potential adverse drug reactions.

The conferees expect that participating pharmacists will review the medication profile of beneficiaries for potential adverse reactions before filling prescriptions. The conferees further intend that carriers will review claims retrospectively to identify practitioners exhibiting a pattern of inappropriate drug prescribing or dispensing.

The conference agreement also requires the Secretary to establish an educational program to educate physicians and pharmacists about inappropriate prescribing and dispensing practices. This program is expected to include a range of educational interventions, ranging from written to face-to-face communications.

(2) The conference agreement includes the Senate amendment with modifications.

The conference agreement does not include the Senate provision which would have required the use of diagnosis codes on all prescriptions. The conferees believe this requirement would have been unduly burdensome for physicians. Instead, the conference agreement requires physicians to report the appropriate diagnosis code (or codes) on all claims for services they provide. This information would be available for immediate use for utilization review of physician services (and could be used for prepayment screens) and could be used in the future to facilitate drug utilization review by merging Part B with drug claims data.

To enforce the requirement of submission of diagnosis codes, the Secretary would be authorized to deny payment on assigned claims if the required diagnostic information is not provided. In the case of non-assigned claims, if a physician knowingly and willfully fails to respond to a request by a carrier to provide required information not initially included, the physician could be subject to civil money penalties of up to $2,000. Moreover, if a physician knowingly and willfully continues not to provide the required diagnostic information on the initial claims after being notified of the specific obligation to provide such information, the physician could be subject to civil monetary penalties and or exclusion from Medicare under Section 1842(j)(2)(A) of the Social Security Act.

The conferees intend that the Secretary will take appropriate measures to insure the confidentiality of patient-specific information which has been obtained.

The conference agreement includes the Senate provision on drug utilization review standards with modifications. The Secretary would be required to establish standards for the use of each covered outpatient drug based on accepted medical practice. In establishing these standards, the Secretary would be required to incorporate standards from one (or more) current authoritative compendia as the Secretary may select.

The conferees expect that included among the compendia the Secretary will consider for use are the United States Pharmacopoeia Dispensing Information, volume 1 (Drug Information for the Health Care Professional), the American Medical Association's Drug Evaluations, and American Hospital Formulary Service Drug Information. The conferees expect that the Secretary will use only those compendia which base such standards on a review of published scientific and medical information, which provide for a public comment and review process, and which provide adequate assurances that the panelists who establish standards are free of financial (or other) conflicts of interest.

The Secretary, through rule-making, may modify these standards, for use in the Medicare program, on the basis of published scientific and medical information indicating that such standards are not consistent with the safe and effective use of such drug.

The conference agreement also specifies that nothing in Title XVIII of the Social Security Act should be construed as authorizing the Secretary to establish a formulary by excluding from coverage: (i) any specific covered outpatient drug or class of drugs or (ii) the specific use of any covered outpatient drug with respect to a specific indication, unless the exclusion is pursuant to Section 1862(a)(1) and is based on a finding by the Secretary that such use is not safe or effective. The Secretary could, however, exclude certain drugs pursuant to Section 1862(c), relating to exclusions for drugs subject to a proposed order by the FDA to withdraw marketing approval, or 1861(t)(4)(A), relating to the definition of covered home IV therapy drugs (*See* subparagraph (b), above).

(k) *Treatment of Certain Prepaid Organizations.*—The conference agreement does not include the House provision or the Senate amendment. (*See* subparagraph (q), below.)

(l) *Physician Guide.*—The conference agreement includes the Senate amendment with a clarification. The Secretary is required to mail the guide by January 1 of each year, beginning in 1991, to participating hospitals, to each physician who routinely provides Part B services, to Social Security offices, to senior citizen centers, and to other appropriate places.

(m) *Special Cost Control Measures.*—The conference agreement includes the Senate amendment with a modification. The agreement requires the Secretary, immediately upon enactment, to begin compiling information on prices charged by manufacturers and by retail pharmacies for covered outpatient drugs. The Secretary shall compare increases in drug prices for each six month period beginning January 1, 1987, with the average semi-annual increase in such prices during the January 1, 1981 to January 1, 1987 period. The agreement also requires the Secretary to review all available information on the use of prescription drugs by Medicare beneficiaries. The conference agreement requires the Secretary to file a report with the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance in May and November of 1989 and 1990 and in May of each succeeding year containing this information.

Each report submitted after 1991 will also include an explanation of the extent to which increases in expenditures for covered outpatient drugs are the result of price increases by manufacturers and pharmacists and increased drug use by beneficiaries and will include information: (i) on the projected budgetary status of the prescription drug trust fund for the succeeding year; (ii) projected increases in manufacturer's and pharmacists' prices; (iii) the projected level of utilization of covered outpatient drugs by beneficiaries; and (iv) projected administrative costs.

The conference agreement requires the Secretary to submit monthly reports to the Congress, from October 1991 through April 1993, showing monthly outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund.

The agreement further specifies that the Secretary's May 1, 1992 and 1993 reports will determine whether the anticipated outlays and receipts of the new trust fund are sufficient to achieve the established contingency reserve margin for 1993 and 1994. If not, the report will recommend necessary changes (which will also be published in the Federal Register by May 1 as a proposed regulation). Any such recommended changes should appropriately address each of the causes of increased or unanticipated costs for the program.

If the Secretary has published a proposed regulation by May 1 of 1992 or 1993, the Secretary may publish a final regulation during the last 3 days of September of such year to implement the changes proposed. Such changes will become effective as of January 1 of the next year and will apply only during such year and will take effect notwithstanding any other provisions of this part.

Several limitations, however, would apply to the Secretary's cost control authority. First, the final regulation may not provide for a net reduction in outlays in excess of the net reduction provided in the proposed regulation. Second, the Secretary may not provide for a formulary in violation of the prohibition contained in subparagraph (j). Third, the Secretary may not change the methodology for calculating whether the drug deductible has been met (but could change the level of the deductible). Finally, the Secretary could not increase the coinsurance above the level in effect during the previous year.

The conferees intend that, in designing any cost control recommendations, the Secretary will attempt to insure that beneficiary access will not be adversely affected.

The conferees expect and encourage the Secretary to make other recommendations concerning legislative changes that would improve the administration of the new outpatient prescription drug benefit. Such recommendations would be subject to approval by the Congress as part of the normal legislative process.

The conferees understand that the proposed and final regulations will not be reflected in the Congressional Budget Office's August baseline for FY 1993 and FY 1994.

(n) *High Volume Pharmacies.*—The conference agreement includes the Senate amendment with a modification limiting the Secretary's authority to reducing the administrative allowance for mail service pharmacies. Such reductions (if any) must be based on differences between mail service pharmacies and other pharmacies with respect to operating costs and other economies.

(o) *Report on Payment Limits.*—The conference agreement deletes this provision. The conferees intend to request, by letter, the Office of Technology Assessment to prepare a study on possible alternative payment methodologies.

(p) *Report on Covered Outpatient Drug Index.*—The conference agreement does not include the House provision.

(q) *Participating Pharmacies.*—

(1)(A).—The conference agreement includes the Senate amendment. The conferees note that some prepaid health plans operate pharmacies which charge members of the plan less than the pharmacy charges members of the general public. In this case, the conferees intend that the test of compliance with this provision be based on the pharmacy's charges to members of the general public who are not members of the prepaid health plan.

(1)(B).—The conference agreement includes the House provision.

(1)(C).—The conference agreement includes the House provision with a modification. The Secretary would be required by January 1, 1991 to establish an electronic point-of-sale claims processing system for use by carriers and participating pharmacies. Participating pharmacies would be required to transmit information regarding all covered outpatient drugs dispensed to Medicare beneficiaries by such pharmacies regardless of deductible status.

The conferees consider the electronic billing system integral to the smooth administration of the prescription drug benefit. The conferees expect that the Secretary will devote the necessary resources to make the electronic system fully and successfully operational by January 1, 1991. Moreover, the conferees expect that the system will be thoroughly tested prior to that date.

(1)(D).—The conference agreement does not include the House or Senate provision.

(1)(E).—The conference agreement includes the Senate amendment.

(1)(F).—The conference agreement includes the Senate amendment.

(1)(G).—The conference agreement includes the Senate amendment with an amendment deleting the exemption for undue hardship. As noted above, the agreement requires the Secretary to implement an electronic point-of-sale system by January 1, 1991. The agreement further requires the Secretary to provide, upon request, such electronic equipment and technical assistance (other than costs associated with obtaining, maintaining, or expanding telephone service) as the Secretary determines may be necessary for a pharmacy to submit claims through the electronic system. Because the equipment would be provided where necessary an exemption for hardship cases is not needed.

The conference agreement requires participating pharmacies to provide information requested by the Secretary in conjunction with biannual surveys conducted by the Secretary to determine average wholesale prices. (see Item 10g).

All of the preceding requirements for participating pharmacies would be first effective for covered outpatient drugs dispensed on or after January 1, 1991. Claims for drugs dispensed during 1990 would be handled by existing Medicare carriers and the beneficiary's deductible status would be determined by these carriers as under current law.

The Secretary would have authority to specify claims processing and payment procedures in the event of temporary failure of the electronic claims processing system.

(2).—The conference agreement includes the Senate amendment with an amendment deleting the requirement that the Secretary submit lists of payment limit to pharmacies in advance of the payment calculation period.

(3).—The conference agreement includes the Senate amendment with a modification. The agreement provides that the audits would assure compliance with requirements for participation and would assure the accuracy of information submitted by pharmacies.

(4).—The conference agreement includes the Senate amendment with an amendment clarifying that the requirement to accept assignment begins at the point where the Secretary, through the electronic point-of-sale system or otherwise, notifies the pharmacy that the beneficiary has met the deductible.

(r) *Civil Monetary Penalty.*—The conference agreement includes the Senate amendment authorizing civil monetary penalties for pharmacies that charge Medicare beneficiaries more than they charge the general public. For purposes of this provision, the price charged to the general public is the pharmacy's price to a customer who is not a member of any group which has obtained a discounted price from that pharmacy, such as an HMO.

The conference agreement also authorizes civil monetary penalties for pharmacies that fail to provide information requested by the Secretary as part of the biannual survey of wholesale prices (see Item 10g).

(s) *Limitation to 60 Day Prescription.*—The conference agreement includes the Senate amendment with an amendment. No payment may be made for any expense incurred for a covered outpatient drug if it is dispensed in a quantity exceeding a 30 day supply, except that the Secretary may authorize a longer supply (not exceeding 90 days, except in exceptional circumstances). Such extended supply policies may apply to specific drugs or classes of drugs and may be subject to appropriate conditions as the Secretary may establish.

(t) *Additional Premium for Prescription Drug Benefit.*—See Item No. 15.

(u) *Use of Carriers in Administration.*—

(1) The conference agreement includes the Senate amendment with modifications.

Current law requires that a Medicare carrier be an insurer of health care services. The conference agreement waives this requirement and authorizes the Secretary to contract with other entities for implementation and operation of the electronic point-of-sale claims processing system and for related functions. Such entities include voluntary associations, corporations, partnerships, or other nongovernmental organizations. Such contracts may be on a regional basis.

If the Secretary requires a carrier to subcontract with such an entity for this purpose, the conferees expect the Secretary to take this arrangement into account in evaluating the carrier's performance. The failure of such entity to properly carry out its responsibilities should not adversely affect the carrier's performance rating.

The conferees further intend that the term "related functions" would apply to functions closely related to the implementation and operation of the electronic system, such as initial claims denials made through the system. Other functions, such as the handling of beneficiary inquiries and carrier fair hearings, would remain with the traditional Medicare carriers.

The agreement permits the Secretary to use fixed-price contracts for electronic claims processing (and related functions) but requires the Secretary to: (i) publish in the Federal Register general criteria and standards used for evaluating contractors and provide opportunity for public comment; (ii) publish in the Federal Register any new policy or procedure that substantially affects the performance of contracts 30 days before such policy or procedure is to take effect; and (iii) negotiate necessary contractual modifications with contractors before requiring them to perform any additional functions.

The conferees expect that the Secretary would initially contract with more than one entity to establish more than one electronic system.

The agreement specifies that current law requirements regarding coordination of benefits payments with Medicare supplemental insurers will not apply to covered outpatient drugs until January 1, 1993.

(2) The conference agreement includes the Senate amendment with a modification. The agreement requires contractors processing claims for prescription drugs to provide for a monthly payment cycle. All claims received and approved for each participating pharmacy or individual submitting claims in the period since the previous payment date would be paid at the end of the payment cycle.

The conferees understand that under this system, claims would be paid, on average, 15 days after receipt. If payment is delayed more than 5 days after the requisite payment date, interest shall accrue until payment is made.

(3) The conference agreement includes the Senate amendment.

(v) *Modification of HMO/CMP Provisions.*—

(1) The conference agreement does not include the House provision or the Senate amendment.

(2) The conference agreement includes the Senate amendment.

(3) The conference agreement includes the Senate amendment.

(w) *Medicaid Requirements.*—See Item No. 33.

(x) *Beneficiary Drug Cost Survey and CBO Report.*—

(1) The conference agreement includes the Senate amendment with a modification. Data obtained from the 1987 National medical Expenditure Survey (NMES) would be used in lieu of conducting a new survey. Based on this data, the Secretary would submit a report on expenses incurred by Medicare beneficiaries for outpatient drugs to Congress by April 1, 1989. Also by this date, the Secretary would provide the Director of the Congressional Budget Office any data from the survey that the Director may request to make the estimates required under subparagraph (2) below.

(2) The conference agreement includes the Senate amendment with an amendment specifying the CBO report is due by June 1, 1989, or 60 days after the date the Secretary provides the requested data under subparagraph (1). The report is to include estimated outlays and revenues (with projected trust fund balances) for the period from FY 1990 through FY 1993.

(3) The conference agreement does not include the Senate amendment.

(y) *Prescription Drug Payment Review Commission.*—The conference agreement includes the House provision with an amendment. The Commission is to be established by January 1, 1989. The conferees expect that one of the eleven commissioners would be associated with a brand name drug manufacturer while another would be associated with a generic drug manufacturer.

The Commission is directed to submit an annual report to Congress by May 1 of each year, beginning May 1, 1990. The report would concern methods of determining payment for the outpatient prescription drug benefit authorized under this legislation. Beginning in 1992, the annual report must include comments on both the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for any changes necessary to reduce outlays in order to achieve the established contingency margin for the following year. These recommendations are to take into account the causes of increased or unanticipated outlays for covered drugs in the year.

Beginning in 1992, the annual report would also include information on increases in manufacturers' prices for prescription drugs, increases in pharmacies' charges for such drugs, utilization of the outpatient prescription drug benefit by beneficiaries, and administrative costs associated with the benefit.

(z) *Additional Studies.*—The conference agreement includes the Senate amendment with modifications. The requirement for a report on third party coverage is not included. The conferees note that under subparagraph (x) the Secretary is required to conduct a study of drug expenditures by the elderly. It is expected that the issue of third party coverage will be addressed in that study.

The conference agreement provides for a one-time study by the GAO which would include: (i) a comparison of average wholesale drug prices and actual acquisition costs by type of pharmacy; (ii) an analysis of the discounts offered by pharmacies to other third-party insurers; and (iii) an analysis of overhead costs of retail pharmacies. The study would be due to Congress by May 1, 1991.

Pharmacies participating in Medicare or Medicaid would be required to provide the GAO with reasonable access to records needed to conduct the study; non-compliance would be subject to exclusion from Medicare or Medicaid under Section 1128(a) of the Social Security Act. The conferees expect that the GAO would not release any data from the study in a manner which could be identified with individual pharmacies.

The conference agreement does not include a requirement for a study on the potential application of new claims processing and billing technologies. The conferees note that the agreement requires the Secretary to implement an electronic point-of-sale claims processing system.

The conference agreement requires a study of methods to improve utilization review of covered outpatient drugs. The study is due to the Congress by January 1, 1993.

The conference agreement does not include the requirement that the Secretary study alternative payment methodologies for covered outpatient drugs. The conferees note that under subparagraph (o) above, the conferees intend to request the Office of Technology Assessment to conduct a similar study.

The conference agreement also does not include the study on induced demand. The conferees expect that this issue will be addressed in the study required under subparagraph (x).

The conference agreement specifies that the longitudinal study of the use of covered outpatient drugs by Medicare beneficiaries is to be conducted as a follow-up to the 1987 NMES study. The report is due January 1, 1993.

The conference agreement expands the scope of the requisite study on experimental cancer drugs to include other experimental drugs and biologicals. This report is due January 1, 1990.

The conference agreement also requires the Secretary to study the potential of mail service pharmacies to reduce the cost of covered outpatient drugs for beneficiaries and for the Medicare program and to report to Congress by January 1, 1990.

(aa) *Study of the Treatment of Prescription Drugs.*—The conference agreement does not include the Senate amemdment.

(bb) *Simplification of Recordkeeping.*—The conference agreement includes the Senate amendment with modifications. The agreement requires the Secretary to develop a standard claims form and a standard format for electronically submitted claims to be used by Medicare and other third parties for covered outpatient drugs. The Secretary would consult with representatives of pharmacies and other interested individuals in developing these standards. The Secretary would be required to distribute official sample copies by October 1, 1989.

The conference agreement does not include the requirement for demonstration projects testing various electronic billing systems. The conferees note that the Secretary is required to implement a point-of-sale electronic claims processing system.

Effective Date.—Applies to items dispensed on or after January 1, 1990, except for the following.

Prompt payment requirements for carriers take effect on January 1, 1991, but are not to be construed as requiring payment before February 1, 1991, thereby permitting implementation of staggered billing cycles.

Provisions relating to modification of HMO/CMP contracts apply to new enrollments effective on or after January 1, 1990.

Diagnostic coding requirements apply to services furnished on or after April 1, 1989.

11. Coverage of Home Intravenous Drug Therapy (Section 7A of Senate amendment)

Present Law

(a) General.—Drugs and biologicals, which cannot be self-administered and which are furnished as an incident to a physician's professional service, are included within the definition of "medical and other health services," and are covered under Part B. Such coverage also includes antigens prepared by a physician and administered by or under the supervision of a physician.

(b) Payment.—No provision.

(c) Certification.—Except for certain inpatient or outpatient services provided by hospitals, payments for services to providers under Part B may only be made if a physician certifies (and recertifies where such services are furnished over an extended period) that the services are necessary.

(d) Certification of Providers.—The Secretary, in carrying out his functions related to determination of conditions of participation of providers of services, shall consult with appropriate national listing and accreditation bodies, and may consult with appropriate local agencies. If a State imposes higher requirements on institutions as a condition of payment under titles I, XVI, or XIX (Medicaid) of the Social Security Act, the Secretary shall impose like requirements under Medicare.

(e) Intermediate Sanctions for Home Intravenous Drug Therapy Providers.—No provision.

(f) Publication Requirement.—No provision

House bill

No provision.

Senate amendment

(a) General.—Provides for Medicare coverage of intravenous drug therapies provided in the home. Home intravenous therapy is defined as items and services that: (1) are provided to an individual who is under the care of a physician; (2) are provided in the residence used as the individual's home; (3) are provided by a qualified home intravenous drug therapy provider or by others under ar-

rangement with such provider; and (4) are provided under a plan established and periodically reviewed by a physician.

Coverage for home intravenous drug therapy includes nursing, pharmacy and related services as are necessary to safely and effectively conduct an intravenously administered anti-infective or cancer chemotherapeutic drug regimen through the use of a covered outpatient drug or use of any other intravenously administered drug which the Secretary (in consultation with providers, clinicians and consumers) determines may be safely provided in the home.

A qualified home intravenous drug therapy provider is defined as a home health agency certified by the Secretary as meeting certain conditions of particpation, or other entity certified by the Secretary as meeting certain conditions of participation. The conditions of participation require that the home health agency or other entity: (1) is capable of providing or arranging for the provision of home intravenous drug therapy; (2) maintains clinical records; (3) has written policies to govern the provision of services; (4) makes services available 24 hours per day, seven days a week as necessary; (5) coordinates all services with the patient's physician; (6) conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care; (7) assures that only trained personnel provide chemotherapy or any other service where training is required to safely provide the service; (8) assumes responsibility for the quality of services provided by others under arrangements; and (9) meets such other conditions as the Secretary determines are necessary for the safe and effective provision of services and as necessary for the efficient administration of the benefit.

(b) Payment.—Requires the Secretary to establish a fee schedule for home intravenous drug therapy prior to the beginning of each calendar year, beginning prior to calendar year 1990. The fee schedule is to be established on a per diem basis. The fee schedule is to be based on a study of current reimbursement for similar items and services provided under Medicare, on the customary charges for such therapy, and on such other information as the Secretary deems appropriate.

Reimbursement for home intravenous drug therapy is 100 percent of the lesser of the actual charge and the fee schedule amount. Payments for these items and services is not subject to the annual Part B deductible amount.

(c) Certification.—Provides that coverage for home intravenous drug therapy is limited to cases in which a physician certifies that (1) such therapy is required by the individual, (2) a plan for furnishing the therapy has been established and is periodically reviewed by a physician, (3) the therapy is furnished while the individual is under the care of a physician, and (4) the therapy is provided in a place of residence used as the individual's home.

(d) Certification of Providers.—Adds home intravenous drug therapy providers to the list of providers for which the Secretary shall consult with appropriate State agencies and recognized national listing or accrediting bodies, and appropriate local agencies in determining the conditions of participation.

(e) Intermediate Sanctions for Home Intravenous Drug Therapy Providers.—Provides that the Secretary shall develop and implement "intermediate sanctions," in lieu of canceling the certification of the provider, that may be imposed for a period of up to one year against home intravenous drug therapy providers that are determined by the Secretary to no longer meet the conditions of participation. The Secretary shall provide appropriate appeals procedures relating to the imposition of such intermediate sanctions. The intermediate sanctions shall include civil money penalties and suspension of all or part of reimbursement amounts that would otherwise be made under Medicare. Such sanctions are in addition to sanctions otherwise available under State or Federal law.

The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions may be imposed, the amount of any fines and the severity of each penalty. The procedures are to be designed to minimize the time between the identification of violations and imposition of the sanction, and shall provide for the imposition of increasingly severe fines for repeated or uncorrected deficiencies.

(f) Publication Requirement.—Provides that the Secretary shall publish a list of categories of drugs that are considered covered outpatient drugs with respect to home intravenous drug therapy not later than January 1, 1990.

Effective date.—Applies to items and services furnished on or after January 1, 1990

Conference agreement

(a) *General.*—The conference agreement includes the Senate amendment with amendments.

Covered home IV drug therapy services include nursing, pharmacy, and related items and services (such as medical supplies, IV fluids, delivery, and equipment) as are necessary for the safe and effective administration of covered home IV drugs. Drug therapy services would not be subject to the Part B deductible or to coinsurance.

Drugs used for home IV drug therapy are not included in the definition of covered home IV drug therapy services, and are not included in the reimbursement for these services. Instead, these drugs are covered and reimbursed under the catastrophic prescription drug benefit. (See Item 10 concerning coverage of IV drugs).

A qualified home IV drug therapy provider must comply with requirements contained in the Senate provision. The conference agreement adds the requirement that the provider must adhere to written protocols with respect to provision of services and expands the requirement pertaining to use of trained personnel to cover provision of all home IV drugs. Further, the entity must be licensed, or approved as meeting the requirements for licensure, if State or local law provides for licensure of home IV drug providers.

A home health agency may qualify as a home IV drug therapy provider if it meets these requirements. In this case, the home health agency would not have to be recertified with respect to any conditions that it had previously met to be certified as a home health agency.

(b) *Payment.*—The conference agreement includes the Senate amendment with amendments. Under the agreement, Medicare payment would be the lower of the provider's actual charge or the fee schedule amount.

The fee schedule would be established by the Secretary by regulation before January 1, 1990 and would provide payment on a per diem basis. In establishing the fee schedule, the Secretary could consider cost information, charge information, and payment rates for similar items and services covered under Medicare. The Secretary could not, however, require routine cost reporting.

The conference agreement provides the Secretary with broad flexibility in establishing the fee schedule. The conferees expect that the Secretary will use this flexibility to establish a fee schedule which assures adequate access to services while preventing excessive payments. The conferees note that exclusive reliance on customary charges has previously resulted in excessive reimbursement levels for similar services.

The conferees expect that the availability of home IV therapy will facilitate shorter hospital lengths of stay for a variety of illnesses. The conference agreement therefore requires the Prospective Payment Assessment Commission to study and report to the Congress and the Secretary by March 1, 1991 concerning adjustments to DRG payments which may be appropriate in view of the expected savings to hospitals.

Finally, the conference agreement prohibits a home IV therapy provider from providing services to a Medicare beneficiary based on a referral from a physician who has an ownership interest in, or receives compensation from, the provider. The prohibition would also apply to ownership or compensation arrangements involving an immediate family member of the referring physician. The referring physician is the physician who prescribes the home IV drug therapy or establishes the plan of care for such therapy.

Several exceptions to this prohibition are provided: (i) ownership of publicly traded stock purchased on terms available to the general public; (ii) sole community rural home IV therapy providers as defined by the Secretary; (iii) compensation reasonably related to items or services actually provided by the physician which does not vary in proportion to the number of referrals made; (iv) physicians whose only relationship with the provider is as an uncompensated officer or director of the provider; and (v) other exceptions established by the Secretary by regulation, for ownership or compensation arrangements which the Secretary determines do not pose a substantial risk of program abuse. The exception under clause (iii) would not apply for compensation paid by the home IV provider to the referring physician for direct patient care services. It is expected that the physician would bill Medicare (or the beneficiary) for such services.

Payment would be denied for services provided pursuant to a prohibited referral. The home IV provider would also be prohibited from billing for such services on an unassigned basis. Moreover, a physician who knowingly and willfully makes a prohibited referral or a provider who knowingly and willfully accepts such a referral would subject to civil monetary penalties of up to $15,000 for each such referral and/or exclusion from the Medicare program.

The conferees intend that this prohibition not be construed in any way as altering (or reflecting on) the scope and application of the anti-kickback provisions contained in Section 1128B of the Social Security Act.

The conferees are aware of the growing prevalence of physician ownership and compensation arrangements which are developed and marketed by providers of medical services. These arrangements are often initiated with the intent of binding together the financial interests of referring physicians with those of the providers.

Because of the resulting economic alliance, physicians are less likely to exercise independent judgment in making referral recommendations. Moreover, such alliances pose a risk of inducing over utilization even if the physician's income does not vary in proportion to the number of referrals made.

Some of these arrangements may involve indirect referral fees. Investment opportunities may be restricted to physicians who are able refer substantial business to the provider, and such investments often have returns which are substantially higher than what would be expected for comparable investments.

For these reasons, the conference agreement includes a requirement that the HHS Inspector General conduct a study of physician owneship of, and compensation by, other suppliers of Medicare covered services to which they make referrals. The report would (i) include a description of the full range of such arrangements and the means by which they are marketed to physicians; (ii) evaluate the potential of such arrangements to influence physician decisionmaking and to result in inappropriate utilization; (iii) assess the practical difficulties involved in enforcement actions under current anti-kickback provisions; and (iv) make recommendations regarding possible changes in the law to strengthen protections against program abuse. The report would be due to Congress by May 1, 1989.

(c) *Certification.*—The conference agreement includes the Senate amendment with an amendment.

The conference agreement requires that all home IV therapy services be reviewed and approved for medical necessity and quality by a Peer Review Organization (PROs) during a three-year period (1990–1992).

Prior approval by a PRO is required for home IV therapy initiated immediately upon hospital discharge. Except in exceptional circumstances (specified by the Secretary), home IV therapy services initiated on an outpatient basis (without a preceding hospital stay) must be approved by the PRO within one working day after the initiation of therapy. PROs would be required to complete reviews within one working day of receipt of a request for review.

To assure the validity and uniformity of PRO reviews, the conference agreement requires the Secretary to establish criteria that would be used by PROs in conducting reviews with respect to the appropriateness of home IV therapy services. Such criteria should assure that beneficiaries are discharged from hospitals to home IV therapy only if this is appropriate from a medical standpoint and the patient (or a family member) is able to carry out the home care regimen properly.

The conferees expect that after 1982, the Secretary could require PROs to conduct some focused reviews and could require prior approval in appropriate circumstances.

(d) *Certification of Providers.*—The conference agreement includes the Senate amendment with a clarifying amendment specifying that a home IV drug therapy provider is a "provider" of services as defined under Medicare.

The conference agreement further requires the Secretary, in consultation with State agencies and other organizations to develop conditions of participation for home IV drug theraphy providers.

(e) *Intermediate Sanctions for Home Intravenous Drug Therapy Providers.*—The conference agreement includes the Senate amendment.

(f) *Publication Requirement.*—The conference agreement includes the Senate amendment.

Effective date.—Applies to services furnished on or after January 1, 1990.

12. In-Home Care for Certain Chronically Dependent Individuals (Section 203 of House bill)

Present law

No provision.

House bill

(a) Services Covered.—Adds a new benefit to Part B of Medicare: in-home care for a chronically dependent individual for up to 80 hours in any calendar year. [Such care provided on any day for 3 hours or less is counted as 3 hours.]

Defines "in-home care" as including (1) services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary); (2) personal care services; and (3) nursing care provided by a licensed professional nurse. Requires that these services be furnished, under the supervision of a registered professional nurse, by a home health agency or others under arrangements with the agency. Also requires that the services be furnished in a place of residence used as the chronically dependent individual's home.

(b) Persons Eligible.—Provides that the above services be available to chronically dependent individuals who are Medicare beneficiaries. Defines "chronically dependent individual" as a person who (1) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 specified activities of daily living (ADLs); and (2) without this assistance could not perform these ADLs. Specifies that the individual be dependent in at least 2 of the following ADLs: eating, bathing, dressing, toileting, or transferring in and out of a bed or in and out of a chair.

(c) Payment.—Provides that payment for in-home services be made on the basis of hourly rates based on reasonable costs of furnishing care.

Requires the Secretary to provide for an appropriate adjustment to payment rates for prepaid health plans paid on a reasonable cost basis to reflect the new catastrophic protection. The adjustment is to reflect: (1) the aggregate increase in payments which would otherwise be made for enrollees if they were not enrolled in the organization; or (2) the amount that would be paid to the organization or facility if payments were made on an individual by individual basis. The organization is required to provide assurances, satisfactory to the Secretary, that it will not undertake to charge an individual more than 20 percent of reasonable costs plus any deductible amounts.

(d) Certification.—Requires a physician to certify, in the case of in-home services provided to a chronically dependent individual during a 12-month period, that the individual was chronically dependent during the immediately preceding 3-month period.

(e) Standards for Utilization.—Specifies that payment may not be made for in-home care for chronically dependent individuals unless such care is reasonable and necessary to assure the health and condition of the individual is maintained in the individual's non-institutional residence. The Secretary is required to take appropriate efforts to assure the quality and provide for the appropriate utilization of in-home care for chronically dependent individuals.

(f) Study of Alternative Out-of-Home Services.—Requires the Secretary to study and report to Congress, within 18 months of enactment, on the advisability of providing to chronically dependent individuals (eligible for services under this provision) with out-of-home services (such as adult day health services or nursing facility services) as an alternative to in-home care.

(g) Study of In-Home Care.—Requires the Secretary to study and report to Congress by June 1, 1991, on the extent of use, cost, and effectiveness of in-home care provided chronically dependent individuals under this provision. [See also item 25]

Effective date.—(a) through (e) apply to items and services furnished on or after January 1, 1989, and before January 1, 1992. Study provisions (f) and (g) effective on enactment.

Senate amendment

No provision.

Conference agreement

(a) *Services Covered.*—The conference agreement includes the House provision, with the amendment noted below regarding the 12 month period of eligibility for the services.

(b) *Persons Eligible.*—The conference agreement includes the House provision, with an amendment. It retains the definition of chronically dependent individual. However, such an individual qualifies for these services only if the individual has been determined either: (i) to have incurred expenses for Part B coinsurance and deductible payments in an amount equal to the catastrophic limit on Part B cost-sharing for the year; or (ii) to have incurred expenses for covered outpatient drugs equal to the outpatient drug deductible for the year. In-home services would then be available to such a beneficiary for 12 months from the date the beneficiary was determined by the Medicare carrier to have incurred such expenses.

If a beneficiary met a second limit within twelve months after meeting a prior limit, this would initiate a new twelve month period of eligibility. In this situation, the beneficiary would be entitled to receive up to 80 hours of care during the new eligibility period, but could not carry over any hours not used during the prior eligibility period. Moreover, in no event could a beneficiary receive more than 80 hours of care during a calendar year.

An individual receiving these services would be responsible for 20 percent coinsurance, notwithstanding that he or she had already met the Part B catastrophic limit in the current year. However, these coinsurance payments could be counted towards the catastrophic limit, during the calendar year in which they were incurred.

The Secretary would be required to take appropriate measures to assure that HMO members who would otherwise qualify for this benefit are properly identified.

(c) *Payment.*—The conference agreement includes the House provision.

(d) *Certification.*—The conference agreement includes the House provision.

(e) *Standards for Utilization.*—The conference agreement includes the House provision.

(f) *Study of Alternative Out-of-Home Services.*—The conference agreement includes the House provision.

(g) *Study of In-Home Care.*—The conference agreement does not include the House provision.

Effective Date.—The conference agreement applies to services furnished on or after January 1, 1990.

13. Extending Home Health Services (Section 204 of House bill; Sections 7 and 8 of Senate amendment)

Present law

(a) Intermittent/Daily Home Health Care.—Home health services are covered under Medicare if the services are required because the individual is homebound and requires skilled nursing care on an intermittent basis or physical or speech thereapy. Current program guidelines specify that to meet the requirement for intermittent skilled nursing care, an individual must have medically predicable recurring need for skilled nursing services. The guidelines define "intermittent" as permitting daily skilled nursing visits for up to eight hours a day for up to two or three weeks if medically reasonable and necessary. Daily is defined as five, six, or seven days per week.

(b) Homebound.—Comparable provision included in the Omnibus Budget Reconciliation Act of 1987, section 4024 of Public Law 100-203.

House bill

(a) Intermittent/Daily Home Health Care.—Specifies that nursing care and home health aide services are considered intermittent if they are furnished less than 7 days a week. These services may be provided 7 days a week for an initial period up to 35 consecutive days. More than 35 consecutive days may be covered if the physi-

cian certifies that exceptional circumstances require additional care on a daily basis.

Effective date.—(a) Applies to services furnished on or after January 1, 1989.

Senate amendment

(a) Intermittent/Daily Home Health Care.—Provides that nursing care and home health aide services may be provided 7 days a week (with one or more visits per day) for up to 21 days with a physician's certification of the need for such care. For a beneficiary enrolled in Part B, up to 45 days of consecutive care would be allowed if he was discharged from a hospital or skilled nursing home within 30 days prior to beginning home health care.

Effective date.—(a) Applies to items and services furnished after December 31, 1987.

Conference agreement

(a) *Intermittent/Daily Home Health Care.*—The conference agreement includes the Senate amendment with a modification. The agreement provides that nursing care and home health aide services may be provided 7 days a week (with one or more visits per day) for up to 38 consecutive days. The conferees intend that current coverage policies which allow for additional days of care under unusual circumstances would continue to be covered under Medicare.

The conference agreement further extends the favorable presumption under the waiver of liability provisions for skilled nursing facilities and home health agencies. The Secretary is prohibited from modifying the presumption criteria for these waivers through October 1990.

The conference agreement requires the Administrator of the Health Care Financing Administration to appoint an 11 member Advisory Committee on Home Health Claims. At least five members shall be representatives of home health agencies or visiting nurse associations. The remaining members are to be representative of physicians' groups, senior citizens' groups and fiscal intermediaries, with no more than 3 members representative of fiscal intermediaries. The advisory committee is to study the reasons for the increase in the denial rate for home health claims during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials. A report on the committee's findings is due to the Health Care Financing Administration and to the Congress within one year of enactment.

(b) *Homebound.*—The conference agreement does not include the Senate provision. The conferees note that a comparable provision was included in the Omnibus Budget Reconciliation Act of 1987.

Effective date.—The conference agreement applies to home health services furnished on or after January 1, 1990.

14. Increase in Maximum Payment Allowed for Outpatient Mental Health Services (Section 205 of House bill)

Present law

A special limit is applicable with respect to expenses incurred in a calendar year in connection with the treatment of a mental, psychoneurotic or personality disorder of a beneficiary who is not an inpatient of a hospital at the time services are rendered. Medicare recognizes 62.5 percent of reasonable charges for such services. It pays 80 percent of the recognized amount up to a maximum of $250. The Omnibus Budget Reconciliation Act of 1987 increases the maximum payment amount to $450 in 1988 and $1,100 in 1989.

House bill

Increases the medicare outpatient mental health payment limit to $1,000.

A maximum of $250 in out-of-pocket expenses may be counted toward the catastrophic limit. The effective beneficiary coinsurance rate remains the same.

Effective date.—Applies to expenses incurred for services furnished on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision. The conferees note that a provision was included in Section 4070 of the Omnibus Budget Reconciliation Act of 1987 which increased the maximum payment amount for mental health services beyond that provided in this legislation.

15. Adjustments in Medicare Part B Premium (Section 206 of House bill; Sections 5 and 27 of Senate amendment)

Present law

(a) Part B Premiums.—Under current law, premiums for Medicare Part B are charged to Part B enrollees on a monthly basis according to an amount established in advance for each calendar year. The monthly Part B premium for 1988 is $24.80.

During September of each year, the Secretary determines the monthly actuarial rate for the succeeding calendar year for Part B enrollees age 65 and over equal to one-half of the benefits and administrative costs for aged Part B enrollees, including a contingency margin.

The Secretary also determines during September of each year the monthly actuarial rate for disabled enrollees under age 65 for the succeeding calendar year equal to one-half of the benefits and administrative costs estimated to be payable from the Part B trust fund for services and related administrative costs for disabled enrollees under age 65, including a contingency margin.

The current method of determining the monthly premium (temporarily in effect for 1984–89) is to use a formula that sets the premium rate at 50 percent of the monthly actuarial rate for enrollees age 65 and over (i.e., 25 percent of the amount needed to cover program costs for aged beneficiaries). Disabled enrollees pay the same premium.

If there is no Social Security cost-of-living increase (COLA) in a year, the Part B premium is not increased that year. For 1986–89, a beneficiary who has his Part B premium deducted from his Social Security check and experiences a premium increase that is greater than the COLA adjustment, the premium increase is reduced to avoid a reduction in the individual's Social Security check.

Beginning January 1, 1990, the premium will be calculated according to prior law, which provided that the premium would be the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged, or (2) the current premium amount increased by the Social Security COLA.

(b) Catastrophic Coverage Premium.—No provision.

(c) Premium for Prescription Drug Benefit.—No provision.

(d) Benefit Premium for In-Home Care Benefit.—No provision.

(e) Monthly Premiums for Residents of U.S. Commonwealths and Territories.—All Medicare beneficiaries voluntarily enrolled in Part B are subject to the same Part B premium payment rules and receive the same Medicare benefits, including those residing in the U.S. commonwealths and territories. An individual need not be entitled to Part A benefits to voluntarily enroll in Part B.

(f) Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—All Medicare beneficiaries voluntarily enrolled in Part B are subject to the same Part B premium payment rules and receive the same Medicare benefits, including those not entitled to benefits under Part A.

(g) Transfers to Catastrophic Health Insurance Trust Fund.—No provision.

House bill

(a) In General.—Provides for increases to the monthly Part B premium to finance the catastrophic coverage benefit (through the transitional adjustment in 1991 and 1992), the prescription drug benefit (beginning in 1989), and the in-home care benefit (in 1989, 1990, and 1991.)

(b) Catastrophic Coverage Premium.—

(1) Premium Amount.—Provides for a transitional adjustment increase to the monthly Part B premium otherwise determined of $1.00 in 1991 and $1.30 in 1992.

(2) Indexing.—Provides that the transitional increase in 1991 will not be taken into account when determining Part B increases in subsequent years under section 1839(a)(3), but the transitional increase in 1992 will be taken into account when determining Part B increases in 1993 and each subsequent year.

(c) Premium for Prescription Drug Benefit.—Amends section 1839 (amount of the Part B premium) to provide for an additional monthly premium for the prescription drug benefit.

(1) Premium Amount.—Provides that the basic monthly drug premium increase for a year is, subject to certain limits, the monthly actuarial rate. The monthly actuarial rate for the prescription drug benefit for 1989 is $2.30.

Provides that for subsequent years, the Secretary will determine in September of each year, beginning with 1989, (a) the total benefits and administrative costs estimated to be paid from the Part B trust fund for each succeeding year for covered outpatient drugs and related administrative costs, and (b) a monthly actuarial rate for covered outpatient drugs applicable for the succeeding calendar year estimated so that the aggregate amount of the increase in drug premiums collected or received for such year will equal 75 percent of the total estimated cost of drug benefits and administrative costs.

Requires the Secretary to determine in September of each year, beginning in 1990, the aggregate amount of the increase in drug premiums collected or received during the previous year, the total benefits and administrative costs paid from the Part B trust fund during the previous year for covered outpatient drugs and related administrative costs, and whether the premiums were greater or less than 75 percent of the total paid from the Part B trust fund for drugs. Provides that if the Secretary determines that there was a surplus or deficit in the previous year, the monthly actuarial rate for covered outpatient drugs for the succeeding calendar year must be adjusted by the amount of the surplus or deficit.

If the drug premium increase is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

Requires the Secretary in September of each year beginning with 1989 to determine, for purposes of calculating the prescription drug factor used to adjust the supplemental premium yearly, the total monthly drug premium increases estimated to be collected or received in the succeeding year. The calculation is to be made as if the monthly actuarial rate (without regard to any adjustment for surplus or deficit in the previous year) were substituted for the basic monthly drug premium increase.

(2) Limit on Drug Benefit Premium Amount.—Provides a limit on the basic monthly drug premium amount as follows: not to exceed $3.40 in 1990, and in 1991 and subsequent years, not to exceed 120 percent of the basic monthly drug premium increase for months in the preceding year.

(3) Definitions.—No provision.

(4) Report on Projected Excess Premium Increases.—Requires the Secretary to report to Congress in May of each year beginning with 1990 concerning whether the Secretary anticipates that the monthly actuarial rate for the drug benefit for the succeeding year will exceed the limit on the basic monthly drug premium increase for that year. If so, the Secretary is required to include in the report recommendations for changes in policies under Part B sufficient to reduce Part B expenditures for covered outpatient drugs for the succeeding year so that the monthly actuarial rate (as reduced by such expenditure reductions) will not exceed the limit on the basic monthly drug premium amount for the year.

(d) Premium for In-Home Care Benefit.—

(1) Premium Amount.—Requires the Secretary, during September of 1988, 1989, and 1990, to determine (1) the total benefits and related administrative costs estimated to be paid from

the Part B trust fund in the succeeding calendar year for in-home care, and (2) a monthly actuarial rate for in-home care applicable in the succeeding calendar year. The monthly actuarial rate, subject to the adjustment described below, is an amount the Secretary estimates would be necessary so that the aggregate amount of the increase in premiums collected or paid for the year will equal 100 percent of the total benefits and administrative costs paid from the Part B trust fund.

Requires the Secretary in September of 1990, to determine the aggregate amount of the monthly premium increases collected or received for the in-home care benefit during the previous year, the total benefits and administrative costs which were paid in the previous year from the Part B trust fund for in-home care, and whether the amount of the premiums is greater or less than 100 percent of the total costs.

Provides that if the Secretary determines that there was a surplus or deficit in 1989, the Secretary must adjust the monthly actuarial rate otherwise determined for in-home care for 1991 to reduce or increase the aggregate amount of the monthly premium increase accordingly.

Provides that the monthly Part B premium of each individual enrolled in Part B for each month in a year after December 1988 and before January 1992 will be increased by the monthly actuarial rate for that year for the in-home care benefit, except that if the increase is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

(2) Limit on In-Home Care Benefit Premium Amount.—Provides that the increase in the monthly premium for the in-home benefit may not exceed in 1989, $0.30; in 1990, $0.50; and in 1991, 120 percent of the monthly premium increase in 1990. If the monthly actuarial rate for 1991 exceeds 120 percent of the monthly premium increase in 1990, the Secretary is required to decrease the maximum number of hours of in-home care in 1991 by such an amount that will assure that the aggregate amount of the monthly premium increase collected or paid for 1991 for all enrollees is equal to the total benefits and administrative costs estimated to be paid from the Part B trust fund in 1991 for in-home care.

Provides for certain conforming amendments.

(e) Monthly Premiums for Residents of U.S. Commonwealths and Territories.—

(1) Part B Premium.—Provides a separate Part B premium calculation for Medicare beneficiaries who are residents of a commonwealth or territory, defined as Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

For such residents during a month in 1988 or 1989, their monthly Part B premium otherwise determined is increased by one-twelfth of the product of: the average per capita additional benefits and related administrative costs due to the amendments in this bill, excluding benefits under section 202 (prescription drugs and insulin) and section 203 (in-home care), as determined by the Secretary during September of the previous year, times the following ratio. The ratio (determined by the

Secretary for that commonwealth or territory during September 1987) is (1) the per capita actuarial value of Medicare benefits for residents of the commonwealth or territory who are entitled to both Part A and Part B benefits, divided by (2) the per capita actuarial value of the Medicare benefits for residents of the United States who are entitled to both Part A and Part B benefits.

Provides that for 1990, the monthly Part B premium for such residents would be the monthly Part B premium otherwise determined for months in 1989, plus the increase for 1989 described above, increased by the Social Security COLA percentage increase for 1990.

For succeeding years, the Part B premium is the previous year's monthly amount, increased by the Social Security COLA for that year.

Provides that if any premium amount is not a multiple of 10 cents, it is rounded to the nearest multiple of 10 cents.

(2) Drug Premium for Residents of Commonwealth or Territories.—Provides that for residents of a commonwealth or territory, the monthly Part B premium is increased by the product of 133⅓ percent of the basic monthly drug premium for that year, times the ratio determined by the Secretary for that commonwealth or territory. The ratio is the per capita actuarial value of Medicare benefits for residents of the commonwealth or territory entitled to Medicare Part A and Part B, divided by the per capita actuarial value of Medicare benefits for residents of the United States entitled to Medicare Part A and Part B.

(f) Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—

(1) Part B Premium.—Provides a separate Part B premium calculation for Part B only individuals. Defines such persons as those who: (1) are not residents of a commonwealth or territory as defined in the bill; (2) are entitled to Part B benefits; and (3) are not entitled to, or on application without payment of an additional premium would not be entitled to, benefits under Part A.

Provides that in 1989, the monthly Part B premium is the monthly Part B premium otherwise determined under current law, increased by one-twelfth of the per capita additional benefits and related administrative costs that the Secretary estimates will be paid under Part B during 1989 because of the amendments made by this bill, excluding benefits under section 202 (prescription drugs and insulin) and section 203 (inhome care).

Provides that in 1990, the monthly Part B premium is the 1989 monthly premium otherwise determined under section 1839(a)(3), plus the increase for 1989 determined above, increased by the percentage increase in the Social Security COLA for 1990. For succeeding years, provides that the monthly Part B premium is the amount for months in the previous year increased by the percentage increase in the Social Security COLA for that year. If any amount is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

(2) Drug Premium for Part B Only Individuals.—Provides that for individuals enrolled under Part B but not entitled to benefits under Part A, the monthly Part B premium will be increased by 133⅓ percent of the basic monthly drug premium increase for that year.

(g) Transfers to Catastrophic Health Insurance Trust Fund.—No provision.

Effective date.—Provides that the transitional adjustment described in (b), above, applies to monthly premiums for months beginning with January 1991; (c) (related to premiums for the prescription drug benefit) applies to monthly premiums for months beginning with January 1989; (d) (related to premiums for in-home care) applies to monthly premiums for months beginning with January 1989 and ending with December 1991; (e) (related to premiums for residents of commonwealths and territories) applies to monthly premiums for months beginning with January 1988; and (f) (related to premiums for Part B only individuals, and for the conforming amendments) applies to monthly premiums for months beginning with January 1989.

Senate amendment

(a) In General.—Provides for increases to the monthly Part B premium to finance the catastrophic coverage benefit (beginning in 1988) and the prescription drug benefit (beginning in 1990).

Provides that the Part B premium would be calculated as under current law, except that the monthly actuarial rate for aged enrollees and for disabled enrollees would be referred to as the monthly actuarial basic rate for each group, respectively, and that such rate would exclude the costs of comprehensive catastrophic coverage benefits (defined as those payable by Medicare as a result of the enactment of sections 2(a), 3(a), 7(b), 7A, and 11 of this bill) and related administrative costs.

Suspends hold harmless provision for 1988 and reimposes hold harmless for 1989 and thereafter.

(b) Catastrophic Coverage Premium.—

(1) Premium Amount.—Provides that the monthly catastrophic coverage premium amount for 1988 for individuals covered by Part A and Part B of Medicare is $4.

(2) Indexing.—Provides that the monthly coverage premium amount for succeeding calendar years is the previous year's amount, increased by the following percentage. The percentage equals:

(a) the percentage (if any) necessary to increase the estimated total revenues collectible from the monthly catastrophic coverage premiums and the supplemental premiums (determined without regard to the drug premium rate adjustment amount) for the succeeding year by the amount by which the estimated total catastrophic coverage benefits and related administrative costs (including administrative costs for outpatient drug coverage) for such succeeding year exceed such revenues, plus

(b) a percentage related to establishing and maintaining a contingency or a reserve fund.

Provides that the percentage increase for a contingency or a reserve fund for a calendar year before 1993 is the percentage the Secretary determines to be necessary to ensure that before 1993 there is established a contingency fund equal to 20 percent or (if greater) a reserve fund equal to 5 percent. For calendar years after 1992, the percentage is the percentage necessary to maintain either of such funds at such percentages.

Defines "contingency fund" for any calendar year as the percentage determined by dividing (1) the amount of unexpended catastrophic coverage premiums and supplemental premiums (without regard to the drug premium rate adjustment amount) as determined at the end of such year, by (2) the actuarial comprehensive catastrophic benefit amount for the succeeding calendar year.

Defines "reserve fund" for any calendar year as the percentage determined by dividing (1) the amount of unexpended and unobligated catastrophic coverage premiums and supplemental premiums (without regard to the drug premium rate adjustment amount) as determined at the end of such year, by (2) the actuarial comprehensive catastrophic benefit amount for the succeeding calendar year.

Provides that if any monthly premium amount is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

Defines "catastrophic coverage benefits" as the benefits payable by Medicare because of the enactment of the catastrophic coverage provisions in section 2(a), 3(a), 4 and 7(b) of this bill.

Defines "actuarial comprehensive catastrophic benefit amount" for any calendar year as the amount that the Secretary estimates will equal the total of the catastrophic coverage benefits (and related administrative costs) that will be payable from the Federal Catastrophic Health Insurance Trust Fund in that calendar year for Part B enrollees.

Provides that for calendar years after 1988, for enrollees who were entitled to Social Security benefits for November and December of the preceding year and who have the Part B premium deducted from their Social Security checks for December and January, their monthly Part B premium cannot be increased due to the catastrophic benefits if such increase would reduce their Social Security Benefits payable for that January below the benefits payable for that December (after the deduction of the Part B premium).

(c) Premium for Prescription Drug Benefit.—Amends Section 1839 (amount of the Part B premium) to provide that the Part B premium be increased by the monthly catastrophic drug benefit premium amount for the prescription drug benefit:

(1) Premium Amount.—Provides that the monthly catastrophic drug benefit premium amount for any calendar year after 1989 for individuals who are covered by Part B will be an amount equal to 50 percent (40 percent for calendar year 1990 and 45 percent for calendar year 1991, as provided in section 27 of the bill) of the per enrollee actuarial catastrophic drug benefit amount for such year, plus (a) in calendar year 1990, an amount necessary to cover 7.5 percent of the per enrollee

actuarial catastrophic drug benefit amount for 1991 (for a contingency fund), and (b) for calendar years after 1990, an amount (when added to any unexpended amount in the contingency fund for the previous year) necessary to cover 7.5 percent of the per enrollee actuarial catastrophic drug benefit amount for such calendar year.

Provides in section 27 of the bill that for calendar years after 1990, if the Secretary determines that (a) it is appropriate to increase the contingency fund to assure a smooth transition from cash outlays accounting to costs incurred accounting over a multiyear period, and (b) the monthly catastrophic drug benefit premium amount for that year is less than the drug premium limit, the Secretary is authorized to increase the drug premium by no greater than 15 percent, not to exceed the drug premium limits in the bill. Once the transition has been completed, requires the Secretary to maintain the drug benefit contingency fund on the basis of such cost incurred accounting method.

Provides that if the monthly drug benefit premium amount is not a multiple of 10 cents, if will be rounded to the nearest multiple of 10 cents.

(2) Limit on Drug Benefit Premium Amount.—Provides that in calendar years after 1991, the monthly catastrophic drug benefit premium amount cannot exceed $0.90 for 1990 (as provided in section 27 of the bill), $2.00 for 1991, $3.50 for 1992, $4.05 for 1993 (as provided in section 27 of the bill), and for any succeeding year, the amount for the preceding year increased by the percentage by which the Part B beneficiary drug expenditure amount for the 12-month period ending in August in that preceding year exceeds the Part B beneficiary drug expenditure amount for the 12-month period ending in August in the second preceding year.

(3) Definitions.—Defines "catastrophic drug coverage benefits" to mean benefits payable under Part B of Medicare because of the enactment of section 7A (coverage of home intravenous drug therapy) and section 11 (coverage of catastrophic expenses for prescription drugs) of this bill.

Defines "per enrollee actuarial catastrophic drug benefit amount" to mean, with respect to a year, an amount equal to the actuarial catastrophic drug benefit amount for the year divided by the total number of individuals that the Secretary estimates will be enrolled under Part B for the year.

Defines "actuarial catastrophic drug benefit amount" to mean, with respect to a calendar year, the amount that the Secretary estimates will equal the total of the catastrophic drug coverage benefits (and related administrative costs) that will be paid in cash outlays from the Federal Catastrophic Drug Insurance Trust Fund in such calendar year for Part B enrollees.

Defines "Part B beneficiary drug expenditure amount" to mean, with respect to a 12-month period, the average per capita amount expended for a period on outpatient prescription drugs by Part B enrollees (other than such enrolless enrolled in a health maintenance organization, a competitive medical plan, or a health care prepayment plan).

(4) Report on Projected Excess Premium Increases.—No provision. (See section 11 of the Senate amendment relating to Secretarial authority to institute cost control measures to assure that the drug premiums do not exceed the premium limits.)

(d) Premium for In-Home Care Benefit.—No provision.

(e) Monthly Premiums for Residents of U.S. Commonwealths and Territories.—No provision.

(f) Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—

(1) Part B Premium.—Provides that the monthly castastrophic coverage premium amount (which is added to the monthly Part B premium otherwise determined) for individuals who are covered by Part B but not by Part A is an amount that bears the same ratio to the monthly catastrophic coverage premium amount for individuals covered by both Part A and Part B of Medicare, as the actuarial Part B catastrophic benefit amount for that year bears to the actuarial comprehensive catastrophic benefit amount for that year.

Defines the actuarial Part B catastrophic benefit amount for a calendar year as the amount the Secretary estimates will equal the catastrophic coverage benefits and related administrative costs payable from the Federal Catastrophic Health Insurance Trust Fund for that year with respect to such enrollees (excluding any amounts attributable to changes under Sections 2(a), 3(a), and 7(b) of this bill in services performed and related administrative costs incurred in that year for individuals covered under Part A).

Provides that if the monthly premium amount is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

(2) Drug Premium for Part B Only Individuals.—No provision. (The drug premium for Part B only individuals is calculated in the same manner as for Medicare beneficiaries covered by both Part A and Part B).

(g) Transfers to Catastrophic Health Insurance Trust Fund.—Provides that there will be transferred from time to time from the Part B trust fund to the Federal Catastrophic Health Insurance Trust Fund amounts from Part B premiums that are attributable to the catastrophic coverage changes in services performed and related administrative costs incurred in a calendar year (under sections 2(a), 3(a), and 7(b) of this bill).

Provides that there will be transferred from time to time from the Part B trust fund to the Federal Catastrophic Drug Insurance Trust Fund amounts from the catastrophic drug benefit premiums.

Effective date.—Applies to premiums for months beginning after December 31, 1987.

Conference agreement

(a) *In General.*—The conference agreement provides for increases to the monthly Part B premium otherwise determined to finance the catastrophic coverage benefit and the prescription drug benefit. For 1993, revenues from the additional flat Part B premium are estimated to provide approximately 37 percent of the financing for the catastrophic coverage and prescription drug benefits, with the supplemental premium (see section 7, above) providing an estimated 63 percent of revenues. After 1993, the conferees intend that the proportion contributed by the flat premium will be 37 percent; however, the proportion could vary as a result of limits on the allowable change in the supplemental premium.

The conference agreement requires the Secretary of Health and Human Services and the Secretary of the Treasury jointly to (1) publish in the Federal Register, by not later than July 1 of each year beginning with 1993, a notice of the proposed preliminary catastrophic coverage and prescription drug monthly premiums for the following year; (2) report to Congress by no later than September 1 of each year the final premiums for the following year; and (3) publish in the Federal Register during the last three days in September of each year the final premiums for the following year.

The flat premium is adjusted to account for any changes in the supplemental premium resulting from limits specified in this Act (see section 7 for a description of these limits). The adjustment to the flat rate premium is calculated in three steps. First, the current year actual supplemental premium rate is subtracted from what the supplemental premium rate would have been if it had not been adjusted by the limits. This difference is known as either the excess or the shortfall rate. Then, the total supplemental premiums imposed in the second preceding year are compared to the total supplemental premiums as adjusted by the excess or shortfall rate. Finally, this difference is adjusted by the percentage by which the per capita catastrophic coverage premium liability (see section 7) for the second preceding year exceeds or is less than such liability for the fourth preceding year. The resulting amount is then used to establish the new per person monthly flat premium.

The conference agreement provides that the sum of the additional monthly premiums for catastrophic coverage and prescription drug coverage for months after 1993 cannot be less than the sum of these additional premiums for months in the preceding year. If this combined monthly premium is affected by the application of this provision, the premium increase is allocated between the catastrophic coverage premiums and the prescription drug premiums in the same proportion as if this provision had not applied.

If any flat premium increase for a month is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents. If so rounded, premiums will be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of their respective amounts determined without regard to any rounding.

The conference agreement includes the Senate amendment regarding the "hold harmless" provision with a modification that the provision applies to both social security benefits and Railroad Retirement benefits and that such benefits may not decrease due to an increase in the Part B premium in any year.

(b) *Catastrophic Coverage Premium.*—(1) Premium Amount.—The conference agreement provides that the monthly catastrophic coverage premium will be as follows for months occurring in 1989 through 1993:

1989	$4.00
1990	4.90
1991	5.46
1992	6.75
1993	7.18

(2) *Indexing.*—The conference agreement provides that for months in a year after 1993, the catastrophic coverage monthly premium will be the preceding year's premium (without regard to any increase in the premium because it was less than the previous years' premium or because of any adjustment due to limits on the supplemental premium), adjusted by a percentage representing the sum of: (i) the outlay premium percentage, and (ii) the reserve account percentage.

The outlay-premium percentage is the percent by which the per capita catastrophic outlays in the second preceding year exceed (or are less than) such outlays in the third preceding year. An adjustment is provided for changes in the Consumer Price Index (CPI) as follows:

If the CPI's inflation rate increased from the third to the second preceding year, the outlay-premium percentage is adjusted by adding 50 percent of the excess (if any) of (i) the excess of the CPI inflation rate in the second over the third preceding year, over (ii) one percentage point. If the CPI inflation rate decreased from the third to the second preceding year, the outlay-premium percentage is adjusted by subtracting 50 percent of the excess (if any) of (i) the excess of the CPI inflation rate in the third over the second preceding year, over (ii) one percentage point. For this purpose, the CPI inflation rate for any year is defined as the percentage by which the CPI for May of such year exceeds such index for May of the preceding year.

The reserve account percentage for any calendar year is the percentage change in the catastrophic coverage monthly premium for the second preceding year which the Secretary determines would have increased (or decreased) the flat premiums for such year by an amount equal to 37 percent of the shortfall (or surplus) in the Medicare Catastrophic Coverage Account (the "Account") in such year. The shortfall (or surplus) in the Account for any calendar year is determined as the amount by which 20 percent of the catastrophic outlays from the Account in the second preceding year exceed (or are less than) the Account balance at the end of such year (taking into account falt and supplemental premium increases attributable to reserve percentages in prior years that have not yet been credited to the Account).

(c) *Premium for Prescription Drug Benefit.*—The conference agreement provides that the monthly prescription drug premium will be as follows for months occurring in 1991 through 1993:

1991	$1.94
1992	2.45
1993	3.02

For months in a year after 1993, the prescription drug premium will be the preceding year's premium, (without regard to any increase because the premium was less than the previous year's premium or because of any adjustment due to the limits on the supplemental premium), adjusted by a percentage determined in a manner similar to that for the monthly catastrophic coverage premium, with the following changes: (1) in determining the outlay percentage, prescription drug outlays rather than catastrophic coverage outlays are used; (2) in determining the reserve percentage, the Federal Catastrophic Drug Insurance Trust Fund balance (see section 16, below) is used rather than the Account balance; (3) the reserve percentage is 75 percent for 1994, 50 percent for 1995, and 25 percent for 1996 and 1997, instead of 20 percent; and (4) the outlay percentage is deemed to be zero for calendar years before 1998.

(d) *Premium for In-Home Care Benefit.*—The conference agreement does not include the House provision. Revenues to fund the in-home (respite care) benefit are included in the monthly and supplemental catastrophic coverage premiums.

(e) *Monthly Premiums for Residents of U.S. Commonwealths and Territories.*—The conference agreement includes the House provision, with the following amendments. For individuals who are residents of Puerto Rico or of another U.S. commonwealth or territory (including the U.S. Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands), the monthly Part B premium otherwise determined would be increased by a catastrophic coverage monthly premium and a prescription drug monthly premium.

For months in 1989, the catastrophic coverage monthly premium is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory. For months in 1990, the catastrophic coverage monthly premium is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory.

For months in a subsequent year, the catastrophic coverage monthly premium is the resident's preceding year's premium increased by the Secretary's estimate (in September of that preceding year) of the percentage increase in the per capita catastrophic outlays from the Catastrophic Account for the year over such outlays for the preceding year.

For months in 1990, the prescription drug monthly premium is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory. For months in 1991, the prescription drug monthly premium is $1,21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory.

For months in a subsequent year, the prescription drug monthly premium is the resident's preceding year's premium increased by the Secretary's estimate (in September of that preceding year) of the percentage increase in the per capita prescription drug outlays from the Federal Catastrophic Drug Insurance Trust Fund for the year over such outlays for the preceding year.

The Secretary is required to report to Congress, in 1993, on the appropriateness of the level of the Part M premium increases for residents of Puerto Rico and of other U.S. commonwealths and territories.

(f) *Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.*—The conference agreement includes the House provision, with amendments. The agreement provides that for individuals who are entitled to Part B of Medicare but are not entitled to Part A, or would not be entitled to Part A but for payment of the Part A premiums, and who are not residents of a commonwealth or territory, the monthly Part B premiums will be determined as follows. The monthly Part B premium otherwise determined will be increased by a catastrophic coverage monthly premium and a prescription drug monthly premium.

For months in 1990, the catastrophic coverage monthly premium is $8.57, and for months in a subsequent year the premium is one-twelfth of the average actuarial expenses that the Secretary estimates (during the previous September) will be incurred for benefits and administration costs attributable to Part B for which outlays may be made from the Medicare Catastrophic Coverage Account during the year.

The prescription drug monthly premium is $0.53 for months in 1990, $4.61 for months in 1991, and for months in a subsequent year the premium is one-twelfth of the average actuarial expenses that the Secretary estimates (during the previous September) will be incurred for benefits and administration costs attributable to Part B for which outlays may be made from the Federal Catastrophic Drug Insurance Trust Fund during the year.

(g) *Transfers to Catastrophic Health Insurance Trust Fund.*—The conference agreement does not include the Senate amendment. The catastrophic coverage monthly premium is credited to the Medicare Catastrophic Coverage Account and transferred to the SMI Trust Fund.

(h) *Conforming Amendments.*—The conference agreement provides for certain conforming amendments, including (1) those to disregard the receipts and outlays attributable to changes made by this Act when determining (i) the monthly actuarial rate used to establish the Part B premium for aged and disabled beneficiaries, and (ii) the appropriate contingency margin for the PART B trust fund; (2) a provision to disregard the flat and supplemental catastrophic coverage and prescription drug premiums when computing appropriations to the Part B trust fund from the Treasury; and (3) those authorizing payments from the Federal Catastrophic Drug Insurance Trust Fund to organizations with risk-sharing contracts and establishing a method for allocating payment to such organizations from the Part A, Part B, and the Federal Catastrophic Drug Insurance Trust Funds.

Effective Date.—The conference agreement applies (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989.

16. Establishment of Federal Catastrophic Drug Insurance Trust Fund (Section 6A or Senate Amendment)

Present law

A separate trust fund exists in the Treasury of the United States for each part of the Medicare program: the Federal Hospital Insurance Trust Fund (Part A) and the Federal Supplementary Medical Insurance Trust Fund (Part B).

The Part A trust fund includes annual deposits of the hospital insurance taxes collected from employers, employees, and the self-employed, and the monthly Part A premiums from individuals not otherwise eligible for Part A. The Part B trust fund includes deposits of the monthly Part B premiums paid by or on behalf of Part B enrollees, and contributions by the Federal Government from general revenues.

Section 1841 of the Social Security Act applies to the Federal Supplementary Medical Insurance Trust Fund as follows: Section 1841(b) creates and specifies the duties of a board of trustees for the trust fund; section 1841(c) provides for the investment of certain trust fund funds; section 1841(d) authorizes the selling of certain obligations acquired by the trust fund; section 1841(e) provides for the crediting of interest on or proceeds from the sale or redemption of any obligations held by the trust fund; section 1841(f) provides for periodic transfers to the trust fund from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Railroad Retirement Account; section 1841(g) provides for payments from the trust fund for Part B benefit payments and related administrative costs; section 1841(h) provides for payment from the trust fund for costs incurred by the Office of Personnel Management in deducting Part B premiums from Federal annuities; and section 1841(i) provides for payment from the trust fund for certain costs incurred by the Railroad Retirement Board.

House bill

No provisions.

Senate amendment

Creates on the books of the Treasury of the United States a trust fund known as the Federal Catastrophic Drug Insurance Trust Fund.

Provides that such trust fund consists of (1) any gifts and bequests made to the trust fund or to the Department of Health and Human Services for the benefit of the trust fund or any activity financed by the trust fund, and (2) the following amounts transferred to such trust fund: (a) drug benefit premiums transferred from the Part B trust fund, and (b) the drug premium rate adjustment component of the Medicare supplemental premium transferred from the general fund of the Treasury.

Provides that subsections (b) through (i) of section 1841 of the Social Security Act apply to such trust fund in the same manner as they apply to the Part B trust fund.

Requires that all Medicare payments for the home intravenous drug therapy benefit and the prescription drug benefit be made from this trust fund.

Effective date.—Applies to items and services furnished after, and premiums for months beginning after, December 31, 1987.

Conference agreement

The Conference agreement generally follows the Senate amendment. All payments for benefits and administrative costs relating to covered outpatient drugs are to be made from the CDI Trust Fund. The CDI Trust Fund has no borrowing authority.

Receipts attributable to the supplemental prescription drug premium rate are appropriated to the CDI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the CDI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

The Secretary of HHS shall transfer premiums attributable to the prescription drug monthly premium directly to the CDI trust fund rather than through the SMI Trust Fund.

The Secretaries of HHS and Treasury jointly shall: (1) not later than July 1 of 1993 and each year thereafter, announce the preliminary monthly and supplemental prescription drug premiums for the following year; (2) not later than July 1 of 1992 and each year thereafter, publish in the Federal Register the outlays from, and the year-end balance in the CDI trust fund for the preceding year; (3) during the last 3 days of September of 1993 and each year thereafter, publish in the Federal Register the monthly prescription drug premiums for the following year; and (4) not later than October of 1993 and end each year thereafter, announce the supplemental prescription drug premium rate for the following year. The Comptroller General shall report to Congress, not later than September 1 of 1992 and each year thereafter, on the completeness and accuracy of the July 1 Federal Register publication, and after 1992, on the July 1 premium announcement.

With respect to the CDI trust fund, "outlays" and "receipts" are defined as gross outlays and receipts within the meaning of the "Monthly Treasury Statement of Receipts and Outlays of the United States Government," as published by the Treasury Department.

Effective date.—The CDI trust fund provisions are effective after December 31, 1988.

17. Establishment of Federal Catastrophic Health Insurance Trust Fund (Section 6B of Senate Amendment)

Present law

A separate trust fund exists in the Treasury of the United States for each part of the Medicare program: the Federal Hospital Insurance Trust Fund (Part A) and the Federal Supplementary Medical Insurance Trust Fund (Part B).

The Part A trust fund includes annual deposits of the hospital insurance taxes collected from employers, employees, and the self-employed, and the monthly Part A premiums from individuals not otherwise eligible for Part A. The Part B trust fund includes deposits of the monthly Part B premiums paid by or on behalf of Part B enrollees, and contributions by the Federal Government from general revenues.

Section 1841 of the Social Security Act applies to the Federal Supplementary Medical Insurance Trust Fund as follows: Section 1841(b) creates and specifies the duties of a Board of Trustees for the trust fund; section 1841(c) provides for the investment of certain trust fund funds; section 1841(d) authorizes the selling of certain obligations acquired by the trust fund; section 1841(e) provides for the crediting of interest on or proceeds from the sale or redemption of any obligations held by the trust fund; section 1841(f) provides for periodic transfers to the trust fund from the Federal Old-Age and Survivors Insurance trust fund, the Federal Disability Insurance trust fund, and the Railroad Retirement Account; section 1841(g) provides for payments from the trust fund for Part B benefit payments and related administrative costs; section 1841(h) provides for payment from the trust fund for costs incurred by the Office of Personnel Management in deducting Part B premiums from Federal annuities; and section 1841(i) provides for payment from the trust fund for certain costs incurred by the Railroad Retirement Board.

House bill

No provision.

Senate amendment

Creates the books of the Treasury of the United States as a trust fund known as the Federal Catastrophic Health Insurance Trust Fund.

Provides that such trust fund consists of (1) any gifts and bequests made to the trust fund or to the Department of Health and Human Services for the benefit of the trust fund or any activity financed by the trust fund, and (2) the following amounts transferred to such trust fund: (a) amounts from the Part B premiums attributable to the catastrophic benefit changes (excluding the drug benefit) in this bill, transferred from the Part B trust fund, and (b) the aggregate monthly supplemental premiums (excluding the drug premium rate adjustment) plus the amount the Secretary of the Treasury estimates Federal outlays are reduced under Medicaid because of the catastrophic provisions of this bill (after taking into account the provisions of section 14 of the bill related to Medicaid savings and State requirements), transferred from the general fund of the Treasury.

Provides that subsections (b) through (i) of section 1841 of the Social Security Act apply to such trust fund in the same manner as they apply to the Part B trust fund.

Requires that all Medicare payments for the catastrophic benefits in sections 2(a), 3(a), 4, and 7(b) of this bill be made from this trust fund.

Effective date.—Applies to items and services furnished after, and premiums for months beginning after, December 31, 1987.

Conference agreement

(a) *Medicare Catastrophic Coverage Account.*—The conference agreement does not include the Senate amendment. A separate Medicare Catastrophic Coverage Account (the "Account") is established on the books of the Treasury of the United States, to be maintained by the Secretary of the Treasury.

No funds are transferred into or out of the account. The principal purpose of the Account is to index the monthly and supplemental catastrophic coverage premium rates and to assure that over time revenue from these premiums are at least as large as the outlays from the Parts A and B trust funds attributable to the Medicare Catastrophic Coverage Act of 1988. (See discussion of premium indexing under section 7 above.)

Under rules prescribed by the Secretary of HHS, the Account is to be debited for catastrophic outlays. Catastrophic outlays are defined as outlays from the HI and SMI trust funds estimated to be attributable to the Catastrophic Coverage Act of 1988; HI and SMI outlays are to be separately debited from the Account. The Account is to be credited for monthly catastrophic coverage premiums received in the SMI trust fund and supplemental catastrophic coverage premiums received in the SMI trust fund and the Reserve Fund. Such credits and debits shall be made as of the last date of each month based upon receipts and outlays occurring during such month, as estimated by the Secretaries of HHS and Treasury. Interest (at the rate used for purposes of the SMI trust fund) is credited on any positive average Account balance in a calendar quarter and debited on any negative average Account balance in a calendar quarter. Thus, if the Account balance is negative, the Account is debited for principal and interest deemed to be owed to the SMI trust fund.

The Secretaries of HHS and Treasury jointly shall: (1) not later than July 1 of 1993 and each year thereafter, announce the preliminary monthly and supplemental catastrophic coverage premiums for the following year; (2) not later than July 1 of 1990 and each year thereafter, publish in the Federal Register the outlays debited from, and the year-end balance in the Account for the preceding year; (3) during the last 3 days of October of 1993 and each year thereafter, publish in the Federal Register the monthly and catastrophic coverage premiums for the following year; and (4) not later than October 1 of 1993 and each subsequent year, announce the supplemental catastrophic coverage premium rate for the following year. The Comptroller General shall report to Congress, not later than September 1 of 1990 and each year thereafter, on the completeness and accuracy of the July 1 Federal Register publication and, after 1992, and July 1 premium announcement.

Catastrophic health insurance benefits, other than prescription drug and home intravenous therapy benefits, are paid out of the existing medicare Parts A and B trust funds.

Receipts attributable to the supplemental catastrophic coverage premium rate, which are not otherwise appropriated to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (the "Reserve Fund"), are appropriated to the SMI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the SMI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

The Secretary of HHS shall transfer receipts from the monthly catastrophic coverage premium to the SMI trust fund in the same manner as the existing Part B monthly premium.

These supplemental and monthly catastrophic coverage premiums are intended to increase Federal government receipts by the cost of catastrophic coverage benefits (plus a contingency margin). No additional revenues are transferred to the Part A trust fund.

Effective date.—The Account is effective after December 31, 1988.

(b) *Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—To prevent an adverse effect on the HI trust fund balance, a new trust fund, to be known as the "Federal Hospital Insurance Catastrophic Coverage Reserve Fund," (the "Reserve Fund") is established on the books of the Treasury of the United States. The Conferees anticipate that Congress may at some future time transfer funds from the Reserve Fund to the HI trust fund to bolster the solvency of the trust fund. No expenditures from the Reserve Fund are permitted.

The rules for managing the Reserve Fund generally are similar to the rules that apply to the SMI trust fund.

Beginning in 1989, supplemental catastrophic coverage premiums are appropriated to the Reserve Fund, but not exceeding the amount of outlays from the HI trust fund that are debited against the Account. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the Reserve Fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

The Secretary shall in July 1990 transfer an amount of supplemental catastrophic coverage premiums to the Reserve Fund equal to interest deemed to accrue (at the rate used for purposes of the SMI trust fund) from the time HI outlays are debited from the Account in 1989, until the time an equal amount of supplemenal catastrophic coverage premiums are transferred to the Reserve Fund.

Receipts attributable to the supplemental catastrophic coverage premium are first transferred to the Reserve Fund and then, to the extent available, transferred to the SMI trust fund, as described in section 17, above. (Such premium receipts are credited to the Account, whether transferred to the Reserve Fund or the SMI trust fund.)

With respect to the Reserve Fund, "outlays" and "receipts" are defined as gross outlays and receipts within the meaning of the "Monthly Treasury Statement of Receipts and Outlays of the United States Government," as published by the Treasury Department.

Effective date.—The Federal Health Insurance Reserve Fund provisions are effective after December 31, 1988.

18. Trustee Comments on Actuarial Soundness of Basic and Supplemental Catastrophic Benefit Premiums (Section 18 of Senate amendment)

Present law

The Social Security Act currently requires that the Trustees of the Hospital Insurance (HI) and Supplementary Medical Insurance (SI) trust funds report to the Congress not later than April 1 of each year on the operation and status of the trust funds during the preceding fiscal year and on their expected operation and status during the current fiscal year and the next 2 fiscal years.

House bill

No provision.

Senate amendment

Amends section 1817(b) relating to the HI trust fund and 1841(b) relating to the SMI trust fund by inserting a requirement that the Trustees comment in their annual reports with respect to the extent to which the monthly catastrophic coverage premium and the supplemental premium cover the cost of the catastrophic benefits (as defined in section 1839(g)(2)(C)(i) added by this Act) and related administrative expenses payable from the trust funds.

Effective date.—Effective for trustees' annual reports beginning with those issued for fiscal year 1988.

Conference agreement

Under the Conference agreement, the Trustees annual reports on the HI and SMI trust funds are to identify those receipts and outlays in each trust fund which are deemed to be receipts and outlays in the Medicare Catastrophic Coverage Account (see section 17, above). In addition, the HI report is to include information pertaining to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.

The trustees of the CDI trust fund and the Account are to report to the Congress, not later than April 1 of each year, on the operation and status of the CDI trust fund and Account during the preceding fiscal year and on their expected operation and status during the current fiscal year and the next two fiscal years.

Effective date.—Effective for Trustees' annual reports beginning with those issued for fiscal year 1989.

19. Treatment of Prepaid Health Plans (Section 207 of House bill; Section 10 of Senate amendment).

Present law

Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare. Reimbursement of HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

House bill

(a) Adjustment of AAPCC's and Contracts for Risk-Based Eligible Organizations.—Requires the Secretary to: (1) take into account amendments made by this act in estimating the AAPCC under section 1876(a) for eligible organizations with risk sharing contracts under section 1876(a) for portions of contract years occurring after December 31, 1987; (2) modify such contracts, for such portions of contract years, to reflect any adjustments made to the AAPCCs (as required above); and (3) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in terms of their agreements with Medicare beneficiaries to take into account the changes in law required by this act.

(b) Provisions Applicable to Organizations Receiving Reasonable Cost Reimbursement.—Specifics that the following new provisions of this act apply to organizations reimbursed on the basis of reasonable costs: Section 201(a)(1) relating to payment for catastrophic benefits; section 202(b)(1)(C) relating to payment for covered out-patient drugs; section 203(c)(3) relating to payment for in-home care.

Requires the Secretary to provide for an appropriate adjustment in Medicare payment amounts to cost-based HMOs for added benefits.

Requires such organizations to assure the Secretary that they will not charge individuals eligible for:

> Medicare catastrophic coverage for covered services after the individual has incurred out-of-pocket expenses equal to the catastrophic limit; or
>
> More than 20 percent of reasonable cost of covered drugs plus amounts payable due to deductibile; or
>
> More than 20 percent of reasonable costs of respite services plus an amount payable due to the deductible.

Effective date.—Enactment.

Senate amendment

(a) Adjustment of AAPCC's and Contracts for Risk-Based Eligible Organizations.—Similar provision except requires the Secretay to: (1) modify any AAPCC under section 1876(a) for an eligible organization with a risk-sharing contract to take into account the amendments made by section 2(a) of this bill relating to benefits for hospital inpatient services, section 3(a) relating to deductibles and coinsurance for individuals under parts A and B, section 4 relating to limitations on out-of-pocket expenses, section 7(b) relating to payment for in-home care, section 7A relating to home intravenous drug therapy, and section 11 relating to prescription drugs; (2) modify each such contract for portions of contract years occurring after December 31, 1987 to reflect the modifications made (as required above); and (3) require such organizations to make appropriate adjustments in terms of its agreements with Medicare beneficiaries to take into account such amendments.

(b) Provisions Applicable to Organizations Receiving Reasonable Cost Reimbursement.—No provision. See section 4 of the Senate amendment (Item 9e) relating to limitations on cost sharing.

Effective date.—Enactment.

Conference agreement

(a) *Adjustment of AAPCCs and Contracts for Risk-Based eligible Organizations.*—The conference agreement requires the Secretary to modify contracts under sections 1833 and 1976 for portions of contract years occurring after December 31, 1988. Prepaid plans are required to adjust their benefit packages to take the new benefits into account. The AAPCC will be adjusted to take the new beenfits into account under current authority. For provisions describing the treatment of copayments and deductibles when a beneficiary is enrolled in a pre-paid plan reimbursed on a risk basis, see item 9(e).

In assessing the value of benefits under prepaid plans paid on a risk basis the Secretary is required to make a separate actuarial determination for drug benefits and for all other covered benefits.

(b) *Provisions Applicable to Organizations Receiving Reasonable Cost Reimbursement.*—The conference agreement does not include the House provision. For provisions applicable to organizations reimbursed on a reasonable cost basis, see items 9(e), 10(f), and 12(c).

Effective date.—The conference agreement is effective on enactment.

20. Mailing of Notice of Medicare Benefits and Participating Physician Directories (Section 208 of the House bill; Section 9 of Senate amendment)

Present law

Under existing law, there is no requirement for an annual notice to Medicare beneficiaries about the scope of benefits available to them under the Medicare program. Information on Medicare coverage is generally available through the Social Security Administration district offices. As part of the participating physician program created by Public Law 98-369, the Deficit Reduction Act (DEFRA), HHS prepares directories of participating physicians, by area and specialty. These directories are made available in local Social Security offices, through hospitals, and through aging and consumer groups. Also, enrollees are informed by a notice in their Social Security check envelopes that they can obtain a copy free from their Medicare carrier. As of October 1, 1986, all "Explanation of Medicare Benefits" notices sent to beneficiaries on unassigned claims have to include a reminder of the participating physician and supplier program.

House bill

(a) Distribution of Notice of Medicare Benefits.—Amends the Medicare statute by adding new section 1804. Section 1804(a) requires the Secretary to distribute annually a notice containing: (1) a clear, simple explanation of the benefits available under Medicare and health care services for which benefits are not available under Medicare; and (2) a description of the limited benefits for

long-term care services available under this title and generally available under State plans approved under Medicaid. Requires the notice to be mailed annually to individuals entitled to Medicare Part A or Part B benefits.

(b) Authorization of Funds.—Amends the Medicare statute by adding a new provision (1804(b)) which authorizes, to be appropriated in equal portions from the HI and SMI trust funds, such sums as may be required to provide for the annual publication and distribution of the notice described in (a).

(c) Distribution of Participating Physician Directories.—Amends section 1842(h)(6) of the Medicare law relating to participating physician directories to require that an area directory of participating physicians be sent to each individual enrolled under Part B and residing in that area.

(d) Timing.—Requires the Secretary to provide notice annually.

(e) Consultation Required.—No provision.

Effective date.—First applies to annual rates and directories for 1988. The annual notice would be sent by January 31, 1988, or 3 months after the date of enactment of this legislation.

Senate amendment

(a) Distribution of Notice of Medicare Benefits.—Requires the Secretary to notify each individual who is entitled to benefits under Medicare of: (1) the benefits that are available under the insurance programs established under Medicare (and the major categories of health care that are not covered under those programs); (2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under such programs; and (3) the ways in which such limitations differ for individuals who are covered under the program established under Part B and individuals who are not covered under Part B.

(b) Authorization of Funds.—No provision.

(c) Distribution of Participating Physician Directories.—No provision.

(d) Timing.—Requires the Secretary to provide the notice described in (a) when an individual applies for benefits under Part A or enrolls under Part B, and annually thereafter.

(e) Consultation Required.—Requires the notices to be prepared in consultation with groups representing the elderly and with health insurers.

Effective date.—The requirement for notices for new beneficiaries is effective January 1, 1988. The notice to all beneficiaries applies to annual notices beginning for 1988.

Conference agreement

(a) *Distribution of Notice of Medicare Benefits.*—The conference agreement includes the House provision with modifications. The notice must include, in addition, information on Medicare's limitations on payment (including deductible and coinsurance amounts).

(b) *Authorization of Funds.*—The conference agreement does not include the House provision. General authority already exists in Section 201(g)(1)(A) of the Social Security Act to use Part A and Part B Trust Fund amounts for administrative expenses of the Medicare program.

(c) *Notice Concerning Participating Physicians.*—The conference agreement does not include the House provision requiring distribution of participating physicians directories, but instead modifies current law requirements for notice to beneficiaries regarding the participation program.

The agreement revised the reminder of the participation program currently required on the explanation of medical benefit (EOMB) notices for unassigned claims. The revised reminder would include: (i) a clear statement of the extra amounts (if any) charged by the physician above the Medicare approved charge; (ii) a brief statement of the advantages of receiving services from a participating physician; and (iii) the carrier's toll-free number with an offer of assistance in obtaining names of participating physicians of appropriate specialty and an offer of a free copy of the appropriate participating physician directory.

The conferees expect that the Secretary will consult closely with groups representing beneficiaries and physicians in developing the notice to assure that it can be easily understood by the elderly and conveys an accurate understanding of program policies.

The conferees expect that the revised reminder would be printed in a prominent type face (where possible) near the beginning of the explanation of medical benefits.

The conference agreement also modifies current requirements for an annual notice to beneficiaries concerning the participating physician program. The revised notice (which would be in the form of a brochure) would be mailed to each beneficiary each year and would contain: (i) a description of the participation program; and explanation of the advantages of obtaining services from a participating physician or supplier; (ii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers; and (iii) the local carrier's toll free number for inquiries concerning the program and for requests for free copies of appropriate directories.

The conferees note that the provisions are based on options developed by the Physician Payment Review Commission in its March 1988 report to Congress and are similar to measures used by private insurers to publicize and facilitate the use of their participating physician networks.

(d) *Timing.*—The conference agreement includes the House provision regarding distribution of the annual notice required under subparagraph (a) with an amendment that such notices must also be mailed annually when an individual applies for benefits under Part A or enrolls under Part B.

(e) *Consultation Required.*—The conference agreement specifies that the Secretary must first distribute the notice required under subparagraph (a) to beneficiaries not later than January 31, 1989. The revised EOMB notice applies to services furnished on or after January 1, 1989. The revised annual notice regarding the participation program would apply to annual notices beginning with 1989.

21. Benefits Counseling and Assistance for Certain Medicare and Medicaid Beneficiaries (Section 9A of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

(a) Training and Technical Assistance.—Authorizes the Secretary to enter into agreements with private or public nonprofit agencies or organizations for the purpose of training volunteers. These volunteers are to provide counseling to elderly individuals, ages 60 and above, receiving benefits under Medicare or Medicaid with respect to eligibility for such benefits and are to provide assistance in preparing documentation that may be required to receive such benefits. In addition to other specified forms of technical assistance, the Secretary may provide material to be used in making elderly persons aware of the availability of assistance under volunteer assistance programs. The Secretary may also provide technical publications and materials to be used by the volunteers.

(b) Powers of the Secretary.—Authorizes the Secretary: (1) to provide assistance to organizations which demonstrate that their volunteers are adequately trained and competent to render effective benefits counseling and assistance to the elderly; (2) to provide for and assist in the training of such volunteers; (3) to provide reimbursement to volunteers for transportation, meals, and other expenses incurred by them during training or in providing counseling and assistance, and to provide such other support as the Secretary deems appropriate; (4) to provide for the use of services, personnel and facilities of the Federal executive agencies and of State and local public agencies with their consent, with or without reimbursement; and (5) to prescribe such rules and regulations as the Secretary deems necessary.

(c) Employment of Volunteers.—Provides that service as a volunteer under this section shall not be considered Federal employment. Volunteers are not subject to provisions of law relating to Federal employment, except that the volunteers are subject to the prohibition against the unauthorized disclosure of confidential information as if they were Federal employees. Reimbursement for expenses received by the volunteers are exempt from taxation.

(d) Authorization of Appropriations.—Authorizes to be appropriated $2.5 million for fiscal years after 1987.

Effective date.—Enactment.

Conference agreement

(a) *Training and Technical Assistance.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to establish a 3-year demonstration project with a private or public nonprofit agency or organization for the purpose of training volunteers.

(b) *Powers of the Secretary.*—The conference agreement includes the Senate amendment, with a modification that deletes the authority of the Secretary to prescribe rules and regulations deemed necessary to carry out the provisions of this section.

(c) *Employment of Volunteers.*—The conference agreement includes the Senate amendment.

(d) *Authorization of Appropiations.*—The conference agreement includes the Senate amendment, with an amendment authorizing appropriations, in appropriate parts from the HI and the SMI trust funds for fiscal years 1989, 1990, and 1991, such sums as may be necessary to conduct the demonstration project.

Effective date.—The conference agreement is effective for calendar years 1989, 1990 and 1991.

22. Case Management Demonstration Projects (Section 16 of Senate amendment)

Present law

"Case management" is a system under which a designated person or organization has responsibility for overseeing health care services for individuals assigned to the person or organization. Where case management is used, an insurer usually will not pay (or will pay less) for those services that are provided without permission of the case manager. Under current law, there are no requirements for Medicare beneficiaries to receive case management services, and case management is not a covered service under Medicare. Utilization and quality control peer review organizations (PROs) are responsible for reviewing the necessity and quality of services for Medicare beneficiaries.

House bill

No provision.

Senate amendment

(a) *Description of Projects.*—Requires HHS to establish not less than six demonstration projects under which a PRO agrees to provide case management services to Medicare beneficiaries with selected catastrophic illnesses.

(b) *Purpose of Projects.*—Specifies that the purpose of the demonstrations is to provide the Secretary and Congress with the information necessary (1) to evaluate the appropriateness of providing case management services under Medicare for individuals with catastrophic illnesses, and (2) to determine the most effective approach to implementing a case management system under the program for such individuals.

(c) *Agreement.*—Requires the agreement with the PRO to specify (1) the catastrophic illnesses for which case management services will be provided, (2) the payments to be made to the PRO for carrying out the project, and (3) such other terms and conditions as the Secretary and the PRO may agree to.

(d) *Waivers.*—Requires the Secretary to waive any provisions of Part B of title XI (relating to general provisions and Peer Review) and title XVIII of the Social Security Act (relating to Medicare) that the Secretary determines would prevent the establishment of a demonstration project under this provision.

(e) Duration.—Provides that the demonstration projects shall be conducted for a 1-year period. The Secretary may terminate the project before the end of the year if he determines that the State conducting the project is not in substantial compliance with the terms of the agreement with the PRO.

(f) Information and Reports.—(A) Requires a PRO with an agreement under section (a) to provide the Secretary with such information as the Secretary determines to be needed to evaluate the results of the project conducted by the PRO. (B) Requires the Secretary to submit an interim report based on information derived from the first 6 months of project operations, containing the findings, recommendations and conclusions of the evaluation of the project as described above.

(g) Authorization to Use Certain Funds.—Requires the Secretary to transfer from the HI and SMI trust funds amounts not to exceed $2 million to carry out the demonstration projects. Provides that amounts are to be transferred without regard to amounts appropriated in advance in appropriation acts. Requires payments from the trust funds to be made in such amounts as the Secretary determines to be fair and equitable.

Effective date.—Requires the Secretary to have the demonstrations in place 12 months after enactment. The interim reports are due 6 months from the date on which the demonstrations are initiated.

Conference agreement

(a) *Description of Projects.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to establish 4 demonstration projects under which an appropriate entity agrees to provide case management services to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services. A further amendment requires that at least one of the demonstration projects be conducted by a peer review organization (PRO).

(b) *Purpose of Projects.*—The conference agreement includes the Senate amendment, with an amendment that the demonstration projects are to evaluate the appropriateness of, and determine the most effective approach of, providing case management services for Medicare beneficiaries with high costs of medical care.

(c) *Agreement.*—The conference agreement includes the Senate amendment, with an amendment that the demonstration project agreements must specify the high cost cases to which case management services will be provided.

(d) *Waivers.*—The conference agreeement includes the Senate amendment, with an amendment requiring the Secretary to waive (in addition to provisions of Part B of Title XI of the Social Security Act) any of Medicare's limitations or restrictions on benefits necessary to conduct the demonstration projects.

(e) *Duration.*—The conference agreement includes the Senate amendment, with an amendment that the data collection phase of the demonstration projects will be conducted for a 2-year period, with an additional period of time to write the report and submit it to Congress.

(f) *Information and Reports.*—The conference agreement includes the Senate amendment, with an amendment that the interim report will be based on information derived from the first year of project operations, and the final report will be based on data derived from the projects.

(g) *Authorization to Use Certain Funds.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to transfer, from the HI and the SMI trust funds in proportions the Secretary determines are appropriate, an amount not to exceed $2,000,000 in each of 2 years for administrative costs to carry out the demonstration projects.

Effective date.—The conference agreement requires the Secretary of HHS to establish the demonstration projects within 12 months after the date of enactment.

23. Changes in Certification of Medicare Supplemental Health Insurance Policies (Section 209 of House bill; Section 13 of Senate amendment)

Present law

(a) Establishment of New Medigap Standards.—Under section 1882 of the Social Security Act, insurers who market private insurance policies to fill the gaps in Medicare's coverage may have the policies certified as Medicare supplemental health insurance policies by the Secretary if the policies meet minimum standards. These standards were developed and approved by the National Association of Insurance Commissioners (NAIC) on June 6, 1979, and are incorporated by reference in section 1882 of the Social Security Act. Policies that are certified by the Secretary may be marketed as Medicare supplemental policies. However, if a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements.

(b) Required Mailing of Notice.—Section 1882 (e) requires the Secretary to provide to individual Medicare beneficiaries information that will permit them to assess the value of the Medicare supplement policies to them and the relationship of any such policies to benefits under the Medicare program.

(c) Required Submission of Advertising.—There is currently no Federal requirement that insurance companies submit their Medigap advertisements for review to the State Commissioners of Insurance.

(d) Transition for Current Policies.—There is no present law relating to transition periods for current Medigap policies.

(e) Free Look Period.—Under the existing NAIC standards, Medigap policies are required to provide a "free look" period of 10 days for policies sold by mail, during which a policyholder may return the policy and get a full refund of any premium paid.

(f) Reporting of Information Relating to Loss Ratios.—Section 1882(b)(1) provides for loss ratio targets for Medicare supplemental policies that set a goal for the percentage of insurance premiums that must be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60

percent of the earned premiums for individual policies and 75 percent for group policies.

House Bill

(a) Establishment of New Medigap Standards.—

(1) Requires the Secretary to report to Congress not later than 150 days after the date of enactment of this act, on changes that should be made in the requirements of section 1882(c) of the Social Security Act for certification of Medicare supplemental policies to take into account the changes made by this act, and by any other pertinent acts enacted by the first session of the 100th Congress, and by any recommendations developed by the NAIC;

(2) Expresses the sense of Congress that: (A) Congress will promptly act on such recommendations and provide for appropriate changes in the requirements of 1882(c), and (B) States will be expected to adjust their laws in a timely manner to comply with changes in such requirements.

(b) Required Mailing of Notice.—Adds a new provision to section 1882 requiring that in order to meet the requirements for certification as a Medicare supplementary insurance policy, a policy offered in a State and in effect on January 1, 1988 must send a letter by January 31, 1988 to its policyholders who are entitled to Medicare, explaining: (a) the improved benefits resulting from this and other legislation enacted by the first session of the 100th Congress and (b) how these improvements affect the benefits contained in these policies and the premiums for these policies. Applies to Medicare supplemental policies as of February 1, 1988.

(c) Required Submission of Advertising.—Amends section 1882(b) to require that entities issuing Medigap policies submit their advertisements (whether through written, radio or television medium) used (or, at the option of the State, to be used) for the policy in the State, to the State Commissioner of Insurance for his or her review in accordance with State law.

(d) Transition for Current Policies.—

(1) Suspends (with the exception of Medigap policies sold in States described in (2) below) from January 1, 1988 through December 31, 1988, current Federal penalties under section 1882 for selling policies to Medicare beneficiaries which (a) were sold before the date of the enactment of this act, and (b) would not substantially duplicate health benefits to which they are otherwise entitled under Medicare but for the changes made by this act.

(2) Gives additional time to certain States (to be identified by the Secretary) in which penalties will be suspended. These are States which require legislation (other than legislation appropriating funds) in order for Medicare supplemental policies to be changed to avoid a penalty under section 1882, but the legislature of the State is not scheduled to meet in the 1988 legislative session in which such legislation may be considered. The exception in these States extends to the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Jan-

uary 1, 1989, for which legislation described above may be considered.

(e) Free Look Period.—No provision.

(f) Reporting of Information Relating to Loss Ratios.—No provision.

Effective dates.—Enactment, except that (b) regarding notices to beneficiaries applies to Medicare supplemental policies as of February 1, 1988, and (c) applies to such policies with respect to advertising used on or after January 1, 1988.

Senate amendment

(a) Establishment of New Medigap Standards.—Amends section 1882 by making conforming changes and adding a new provision relating to NAIC amendments of its model regulation of Medicare supplemental (Medigap) policies to reflect the changes in law made by this Act:

(1) Provides that if the NAIC revises the existing model standards for Medigap policies within 90 days after enactment, then those standards will apply as the standard for certification, beginning 1 year later.

(2) Specifies that if the NAIC does not amend the standards within 90 days, the Secretary is required to issue Federal model standards for Medigap policies reflecting the changes in law made by this act, within 90 days, to become effective 1 year later.

(3) Specifies that no Medigap policy may be certified by the Secretary, no certification shall remain in effect and no State regulatory program will be found in compliance with Section 1882, unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be).

(b) Required Mailing of Notice.—Amends Section 1882(e) to require the Secretary to: (a) inform Medicare beneficiaries (and, to the extent feasible, individuals about to become entitled to Medicare) about current laws that prohibit certain marketing and sales abuses and the manner in which they may report any such action or practice to an appropriate official of HHS and (b) establish a toll-free telephone number for individuals to report suspected violations of the laws relating to Medigap standards. Also requires the Secretary to provide Medicare beneficiaries with a listing of the addresses and telephone numbers of State and Federal agencies and offices where information and assistance relating to Medicare supplemental policies may be obtained.

(c) Required Submission of Advertising.—No provision.

(d) Transition for Current Policies.—No provision.

(e) Free Look Period.—Section 1882(b)(1) is amended to require a uniform 30-day free look period for all Medicare supplemental policies, without regard to the manner in which the purchase of the policy was solicited.

(f) Reporting of Information Relating to Loss Ratios.—Amends section 1882(b)(1) to provide that information with respect to the actual ratio of benefits provided to premiums collected under Medigap policies will be reported to the State on forms conforming to

those developed by the NAIC for such purpose, or such ratios will be monitored under the program in an alternative manner approved by the Secretary.

Effective dates.—(a) is effective as provided in the amendment; (b) enactment; changes made by (e) and (f) are effective on the date on which the amended NAIC Model Standards (or Federal Model Standards) become effective under section 1882.

Conference agreement

(a) *Establishment of New Medigap Standards.*—The conference agreement includes the Senate amendment with amendments. The agreement provides for a procedure whereby the current National Association of Insurance Commissioner's (NAIC) model regulation would be amended or replaced as a standard for certification of Medicare Supplemental Insurance Policies. If the NAIC amends the model regulations within 90 days of enactment of this bill, in accordance with requirements in this section then the amended standards would apply as a standard for certification.

The NAIC has made available to the conferees both a model transition regulation, adopted in September 1987 in anticipation of the passage of this bill, and a draft of a new model minimum standards regulation. The conferees believe the transition regulation deals appropriately with the matter of adapting existing, certified policies to the amendments in Medicare made under this Act. The conferees also believe the draft model minimum standards regulation includes many appropriate provisions. The conferees intend and understand that the revised standards will continue to incorporate such provisions, including rules governing matters covered in the existing and draft model standards, such as minimum benefit standards, loss ratios, disclosure requirements and replacement requirements.

The conferees note that the NAIC model transition regulation contains an explicit prohibition on the inclusion of provisions in Medicare supplemental policies which duplicate the benefits covered under Medicare. The conferees believe such an explicit prohibition clarifies the meaning of the current requirements of Section 1882 that supplemental policies may not duplicate Medicare coverage. This amendment requires that the model standards include provisions otherwise necessary to reflect changes in law made by this Act. In enacting this provision, the conferees intend and understand that NAIC will include a similar provision precluding insurers from selling or maintaining Medicare supplemental policies which provide benefits covered by this Act in its final version of the model minimum standards regulation.

The conferees note in particular that Section 5B of the NAIC Transition Regulations provides for (1) a notice to the beneficiary, (2) the filing by the insurer of riders to the policy to eliminate duplication, and (3) the making of an appropriate refund or appropriate premium adjustment for duplicative coverage. The conferees intend and understand that such provisions will be included in the final model regulations. The conferees intend and understand that such appropriate refund or premium adjustments are to be made retroactive to the effective date of the new Medicare benefits enacted in this bill.

The conferees are particularly concerned about beneficiaries not paying for benefits under Medicare supplemental insurance policies that duplicate benefits covered under this Act. The conferees intend not merely to prevent such duplicative coverage from occurring, but also that beneficiaries receive appropriate premium adjustments where this has occurred.

If NAIC does not amend the regulations within 90 days, then the Secretary is directed to promulgate Federal model standards for certification of Medicare supplemental policies to reflect the changes in law made by this Act. Such Federal standards would then be the standards for certification. The conferees intend that such standards would incorporate all matters provided for in the bill and discussed above in this report with respect to the NAIC model standards.

The NAIC model standards (or the Federal model standards, as the case may be) would apply in a State effective on the earlier of (1) the date the State adopts standards equal to or more stringent than the amended NAIC standards (or the Federal standards), or (2) one year after the NAIC (or the Secretary, in the case of Federal standards) first adopts the standards.

The conference agreement also provides that the Secretary, rather than the President, will appoint the four State Commissioners or superintendents of insurance who, together with the Secretary, form the Supplemental Health Insurance Panel.

The conferees note that under this legislation, Medicare coverage of outpatient prescription drugs will begin in January 1991. The conferees do not intend for the enactment of this drug benefit to be construed as requiring current Medicare supplemental policies, which do not otherwise provide coverage for drugs to begin doing so upon enactment. Under the conference agreement, the NAIC (or the Secretary, as the case may be) will determine whether coverage of the drug deductible should be required for certification as a Medicare-certified policy.

(b) *Required Mailing of Notice.*—The conference agreement includes both the House provision and the Senate amendment, with modifications. In States which have enacted the NAIC Transition Regulations, beneficiaries will receive notices from insurers pursuant to the requirements of those regulations. In States which have enacted the final model standards, but not the transition regulations, insurers must send notices to beneficiaries in accordance with the requirements of this provision in order to remain certified. In States which have enacted neither the final model nor the transition regulations, insureers must follow the requirements described in (d) below. The House provision is modified to change each 1988 date to 1989. The Senate amendment is modified to require the Secretary (1) to inform Medicare beneficiaries of how they may report any marketing or sales abuses to HHS or to an appropriate State official, and (2) to publish the toll-free HHS telephone number for individuals to report suspected violations.

(c) *Required Submission of Advertising.*—The conference agreement includes the House provision, with a modification clarifying that the submission of advertisements to the State Commissioner of Insurance (or comparable officer identified by the Secretary) should be in accordance with review or approval as required under State law.

(d) *Transition for Current Policies.*—The conference agreement includes the House provision with amendments. The agreement does not include the provision which waives Federal penalties for knowingly selling policies with duplicative coverage. The agreement provides for the opportunity to sell or maintain certified Medicare supplemental health insurance policies during the period after enactment of the bill in those States which have not adopted standards by January 1, 1989 to reflect the changes in law made by this Act. The agreement provides that for policies sold prior to enactment (but in effect after enactment), a policy is deemed non-duplicative and may be deemed certified in the insurer selling the policy complies with the NAIC Model Transition Regulation by January 1, 1989, as discussed below. For policies sold after the date of enactment, such compliance would be required before the date of sale of the policy.

The conferees specifically intend that as a matter of Federal law, effective January 1, 1989 (for existing policies) or prior to sale (for policies later sold), Medicare supplemental insurance policies no longer include benefits that are provided for under this Act. Further, the conferees intend, that as a matter of Federal law, effective January 1, 1989, insurers whose policies would contain duplicate coverage but for such provision, notify the insured of such change in coverage, of any resulting premium refunds or adjustments, and when such refunds or adjustments will be made. The notice shall include the matters contained in Section 5(B)(1)(a), (b), and (c) of the NAIC model transition regulations and shall be mailed on the later of January 1, 1989 or the date the policy is sold. For this purpose, the insurer would not have to comply with the requirement of Section 5(B) that the notices be in a form approved by the State Insurance Commissioner.

Further, the conferees intend that insurers are required to take all necessary steps to effectuate such refunds or premium adjustments in the most expeditious possible manner, including immediately filing any appropriate riders to insurance policies. The conferees specifically intend and understand that all such appropriate refunds or premium adjustments will be made retroactive to January 1, 1989 or the date on which the policy is sold, whichever is earlier.

The conferees understand that insurers offering policies which are guaranteed renewable will conform their policies to prevent duplication of coverage in accordance with the provisions in this Act.

The conference agreement also requires the Secretary to report to Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC model regulation (or Federal model standards).

(e) *Free Look Period.*—The conference agreement includes the Senate amendment.

(f) *Reporting of Information Relating to Loss Ratios.*—The conference agreement includes the Senate amendment.

(g) Prohibiting Misuse of Social Security or Medicare References.—The Conference agreement prohibits the use of the word "Social Security", "Social Security Account", "Social Security

System", "Social Security Administration", "Medicare", "Health Care Financing Administration", or any acronym, combination, or variation of such words, and any symbols or emblems of such agencies, in a manner which a person or an organization knew or should have known would convey the false impression that any advertisement or other item is authorized by the Social Security Administration, the Health Care Financing Administration or the Department of Health and Human Services.

The conference agreement authorizes the Secretary to impose civil money penalties of not more than $5,000, or $25,000 in the case of a broadcast or telecast, for violations of this prohibition. The total amount of penalties imposed for multiple violations consisting of substantially identical communications or productions could not exceed $100,000 a year. Those who are assessed penalties would be permitted to request a hearing before an Administrative Law Judge and to appeal thereafter to the U.S. District Court of Appeals. In assessing fines and pursuing violators, the Secretary would be required to coordinate his actions with the Justice Department.

The conferees intent that, to the extent feasible, the Secretary would use informal methods to deal with potential violations prior to initiating action under this provision. Such methods might include a letter which identifies a violation or which points out that the addition of a conspicuously-placed disclaimer of affiliation with the Social Security Administration could avoid the need for action under this provision.

The conferees also intend that the authorities established by this provision should supplement, not substitute for, existing authority of the U.S. Postal Service to take action against misleading and fraudulent references to the Social Security Administration in materials which re mailed.

(h) *Civil Money Penalties for Medigap Violations.*—The conference agreement authorizes civil montary penalties, in every case where only criminal penalties currently apply, for deceptive selling practices relating to Medicare supplemental health insurance (medigap) policies. Violations would be subject to a civil monetary penalty of up to $5,000 per violation.

Effective date.—The conference agreement provides that (a) applies as provided in the section and the Secretary is required to provide for the reappointment of members of the Supplemental Health Insurance Panel by not later than 90 days after the date of enactment. The provisions of (b) requiring the Secretary to provide consumer information apply on enactment; and the provision of (b) requiring health insurers to send informational letters to their policy holders apply to Medicare supplemental policies as of January 31, 1989. (c) applies to Medicare supplemental insurance policies as of Janaury 1, 1989, with respect to advertising used on or after such date. (d) applies as provided in the section. (e) and (f) apply on the date the amended NAIC Model Standards (or Federal model standards) become effective under Section 1882 of the Social Security Act. (g) and (h) are effective on enactment and apply only with respect to violations occurring after enactment.

24. Research on Long-Term Care Services for Medicare Beneficiaries (Section 211 of House bill; Section 15 of Senate amendment)

Present law

(a)-(b) Long-Term Care Services.—Medicare does not cover services required for individuals whose chronic conditions require long-term nursing home or home and community-based services. There is no current requirement that the Secretary provide for research relating to long-term care services nor is there any specific authorization for appropriations for such research.

(c) Institute of Medicine Study.—There is no current requirement that the IOM conduct a study on the financing of long-term care.

(d) Treasury Department Study of Tax Incentives for Long-Term Care.—There is no current requirement that the Secretary of Treasury conduct a study on the financing of long-term care. The President has asked the Department of Treasury to review tax policy as it affects the provision of catastrophic and long-term care health insurance.

House bill

(a) Health and Human Services Study.—Requires the Secretary to provide for research relating to the delivery and financing of long-term care services for Medicare beneficiaries. It shall include at least the following: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care services, including whether beneficiaries are eligible for Medicaid benefits for such services; (2) how financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional services; (3) how relatives and Medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services; (4) the quality of long-term care services (in community-based and custodial settings) and how the provision of such services may reduce expenditures for acute health care services; (5) the effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of beneficiaries provided long-term care (other than in a nursing facility).

Defines long-term care services to include nursing home care, home care, community-based services, and custodial care.

(b) Authorization of Appropriations.—Authorizes to be appropriated, in equal parts from the HI and SMI trust funds, $5 million for each of fiscal years 1988, 1989, 1990, 1991, and 1992, to carry out the research described in (a).

(c) Institute of Medicine Study.—No provision.

(d) Treasury Department Study of Tax Incentives for Long-Term Care.—No provision.

Effective date.—Enactment.

Senate amendment

(a) Health and Human Services Study.—No provision.

(b) Authorization of Appropriations.—No provision.

(c) Institute of Medicine Study.—

(1) Requires the Secretary to request the National Academy of Sciences, through the Institute of Medicine (IOM), to contract for an IOM study to (a) explore options for private funding of a portion of long-term care (including methods by which changes in Federal laws, including tax laws, could facilitate such funding) and determine whether such options would be effective as compared to public financing alternatives and would be beneficial to the broad spectrum of populations (including children and adults who have attained and have not attained retirement age) requiring protection; (b) analyze the effect that provision of types of private funding of long-term care would have on public funding of such care; (c) review options for public sector coverage, both means-tested and universal, with respect to their effects on current and future Federal spending for health care; (d) review the effectiveness, quality of life provided, effect on family caregivers, and cost-implications of community-based long-term care, including types of limits necessary to assist beneficiaries and providers in preventing overutilization; (e) analyze, for each approach to provision of care, relative payments derived from users, non-utilizing elderly and employed persons (including both pre-funding and pay-as-you-go); and (f) review sources of financing and coverage of long-term care services in other developed nations and the implications of these findings on the development of similar policies in the United States.

(2) Requires the IOM study to take into account (a) the effect that impending demographic changes (near and long-term) will have on various approaches to service utilization and funding; (b) the impact of the various approaches to funding, both public and private, on access to long-term care services by individuals of all age groups (including children and adults who have attained and not attained retirement age), individuals of different socioeconomic and minority groups, and women; and (c) the effect that membership in these different groups has on the need, the ability to pay, and access to quality long-term care.

(3) Requires the Secretary to enter into appropriate arrangements with the Academy under which the Secretary will be responsible for expenses incurred for the study. Requires the Secretary to transfer from the HI and SMI trust funds amounts necessary to fund the study.

(4) Requires IOM to submit, by October 1, 1989 to the Secretary, the Senate Finance Committee and the House Energy and Commerce and Ways and Means Committees, a report that describes the study, includes a statement of the data obtained, and specifies administrative actions and changes in law that IOM considers to be appropriate to implement the study findings.

(d) Treasury Department Study of Tax Incentives for Long-Term Care.—Requires the Secretary of Treasury to conduct a study of Federal tax policies to promote the financing of long-term care. The study shall identify alternative methods of creating tax incentives to encourage individuals to purchase insurance for long-term care. Requires the study to consider also the cost to the U.S. Treas-

ury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection. Requires Secretary to consult with representatives of the insurance industry, providers of long-term care, and consumers. Requires the Secretary to report the results of the study and make recommendations to the Congress prior to April 1, 1988 of any changes in Federal law that the Secretary determines to be appropriate to promote financing of long-term care. Defines long-term care to include care and services provided by nursing homes, home health agencies and other mechanisms for long-term care delivery.

Effective date.—Enactment.

Conference agreement

(a) *Health and Human Services Study.*—The conference agreement includes the House provision with amendments. To the extent possible, the Secretary is to rely on research that has already been conducted or is underway by the Health Care Financing Administration or the National Center for Health Services Research and Health Care Technology (in their National Medical Expenditures Survey). The Secretary is required to submit interim reports by December 1990 and December 1992, and a final report by June 1994 to the House Committees on Energy and Commerce and Ways and Means, and the Senate Finance Committee describing the findings of the long-term care research required by this provision.

(b) *Authorization of Appropriations.*—The conference agreement includes the House provision.

(c) *Institute of Medicine Study.*—The conference agreement does not include the Senate amendment. The conferees note that the Secretary may contract with the Institute of Medicine to conduct the research required by Section 211(a) of the House provision.

(d) *Treasury Department Study of Tax Incentives for Long-Term Care.*—The conference agreement includes the Senate amendment, with an amendment that reporting date be changed to November 31, 1988.

Effective date.—The conference agreement is effective on enactment.

25. Study of Adult Day Care Services (Section 212 of House bill; Section 24 of Senate amendment)

Present law

Medicare does not provide coverage for adult day care services.

House bill

(a) Survey of Current Adult Day Care Services.—Requires the Secretary to survey adult day care services to collect information on (1) the scope of such services and the extent of their availability; (2) the characteristics of entities providing such services; (3) licensure, certification and other quality standards that are applied to those providing such services; (4) the cost and financing of such services; and (5) the characteristics of the people who use such services.

Defines adult day care services as medical or special services provided in an organized nonresidential setting to chronically impaired persons who are not inpatients in a medical institution.

(b) Report.—Requires the Secretary to report to Congress, within one year after enactment, on the information collected in the survey. Requires the report to include recommendations concerning appropriate standards for adult day care services under Medicare, including definitions of chronically dependent individuals and services in adult day care, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

Effective date.—Enactment.

Senate amendment

(a) Survey of Current Adult Day Care Services.—Identical provision.

(b) Report.—Identical provision.

Effective date.—Enactment.

Conference agreement

(a) *Survey of Current Adult Day Care Services.*—Identical provision.

(b) *Report.*—Identical provision.

Effective date.—The conference agreement is effective on enactment.

26. U.S. Bipartisan Commission on Comprehensive Health Care (Sections 401–408 of House bill; Section 30 of Senate amendment)

Present law

No provision.

House bill

(a) Establishment/Duties.—Establishes a commission to be known as the U.S. Bipartisan Commission on Comprehensive Health Care. Requires that the Commission: (1) examine short-comings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals to comprehensive health care; and (2) make specific recommendations to Congress on Federal programs, policies, and financing needed to assure the availability of comprehensive long-term care services for the elderly and disabled, comprehensive health care services for the elderly and disabled, and comprehensive health care services for all individuals in the United States. Requires the Commission to consider as it makes its recommendations: (1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds; and (2) the most efficient and effective manner of administering these programs.

Defines "comprehensive health care services" as including: (1) inpatient hospital services (including mental health services); (2) skilled nursing facility services, intermediate care facility services, home health services, and other long-term care services; (3) physician services and other outpatient health care services (including mental health services); (4) periodic general physical examinations; eye, hearing, dental, and foot examinations; and other preventive health care services; and (5) prescription drugs, eye-glasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

Defines "comprehensive long-term care services" as including custodial and noncustodial services in facilities, as well as home and community-based services.

(b) Membership.—Requires that the Commission be composed of 15 members appointed as follows: (1) the President will appoint 3 members; (2) the President Pro Tempore of the Senate will appoint, after consultation with the minority leader of the Senate, 6 Members of the Senate, of whom not more than 4 may be of the same political party; and (3) the Speaker of the House will appoint, after consultation with the minority leader of the House, 6 Members of the House, of whom not more than 4 may be of the same political party. The Commission will elect a chairman and vice chairman from among its members. Any vacancy in the membership of the Commission will be filled in the manner in which the original appointment was made and will not affect the power of the remaining members to execute the duties of the Commission.

(c) Meetings.—Specifies that the Commission will meet at the call of its chairman or a majority of its members; a quorum will consist of 8 members, except that 4 members may conduct a hearing. Members of the Commission may not receive compensation but may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) Staff.—Provides that the Commission may appoint and determine the compensation of staff, and may procure the temporary and intermittent services of consultants necessary to carry out the duties of the Commission.

(e) Powers.—Provides that the Commission may hold hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties. The provision requires, upon request of the Commission: (1) the Comptroller General to conduct studies or investigations; (2) the Director of the Congressional Budget Office to provide cost estimates; (3) the head of a Federal agency to provide technical assistance; and (4) the Administrator of General Services to provide on a reimbursable basis administrative support services, which the Commission determines to be necessary to carry out its duties. The head of any Federal agency may detail to the Commission, without reimbursement, any personnel to assist the Commission in carrying out its duties. The Commission is authorized: (1) to use the U.S. mails; (2) to secure directly from any Federal agency information that may be disclosed to enable the commission to carry out its duties; and (3) to accept, use and dispose of gifts or donations of services or property.

(f) Reports.—

(1) Requires the Commission to submit not later than 6 months after enactment a report to Congress on its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report is to include detailed recommendations for appropriate legislative initiatives.

(2) Requires the Commission to submit not later than 1 year after enactment a report to Congress on its findings and recommendations regarding comprehensive health care services for the elderly and disabled and for all individuals in the United States. The report is to include detailed recommendations for appropriate legislative initiatives.

(g) Termination.—Specifies that the Commission shall terminate 30 days after the date it submits its report on comprehensive health care services.

(h) Authorization.—Authorizes $1.5 million for the Commission.

Effective date.—Enactment.

Senate amendment

(a) Establishment/Duties.—Identical provision.
(b) Membership.—Identical provision.
(c) Meetings.—Identical provision.
(d) Staff.—Identical provision.
(e) Powers.—Identical provision.
(f) Reports.—Identical provision.
(g) Termination.—Identical provision.
(h) Authorization.—Identical provision.
Effective date.—Enactment.

Conference agreement

Identical provision.

Effective date.—The conference agreement is effective on enactment.

27. Extension of Social HMO Demonstration Project (Section 210 of House bill)

Present Law

Section 2355 of DEFRA of 1984 (P.L. 99-369) required the Secretary to approve Medicare and Medicaid waivers needed to implement a demonstration project for social health maintenance organizations (SHMOS). These organizations are to provide an integrated package of health, long-term care, and social services on a prepaid capitation basis for persons who voluntarily enroll with the organization. There are currently four demonstration projects.

There is a comparable provision in section 4079 of Public Law 100-203.

House bill

Requires the Secretary to extend, without interruption, through September 30, 1992, the approval of waivers granted under Section 2355 of DEFRA of 1984 for the SHMO demonstration projects described in that provision, subject to the same terms and conditions (other than the duration of the project) established under that provision. It amends section 2355(b)(5) of DEFRA relating to Medicare's risk contract with the HMO to state that all payors will share risk for no more than 2 years, with the organization being at full risk in the 3rd year and in succeeding years. It requires the Secretary to send an interim report to Congress by December 1988 (rather than a final report, as in current law), and it requires the Secretary to submit a final report not later than March 31, 1993.

Effective date.—Enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision. A comparable provision was enacted in Section 4079 of P.L. 100-203.

28. Protection of Medicare Beneficiaries Enrolled in an Eligible Organization With a Risk-Sharing Contract Against Certain Practices (Section 10A of Senate amendment)

Present law

(a) Notice to Medicare Beneficiaries.—No provision.

(b) Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPs.—HMOs/CMPs must provide assurances to the Secretary that they will not expel or refuse to reenroll any individual on the basis of health status or need for health services.

For each instance in which an HMO/CMP fails substantially to provide medically necessary items and services to a beneficiary, the Secretary may impose a $10,000 civil monetary penalty. No other sanctions short of contract termination are available for most other kinds of possible HMO/CMP contract or legal violations.

(Similar provision included in Omnibus Budget Reconciliation Act of 1987, except does not provide for refund to enrollee of excess charge and does not include extra $15,000 penalty for each individual not enrolled as a result of improper marketing practices.)

House bill

No provison.

Senate amendment

(a) Notice to Medicare Beneficiaries.—Requires an HMO or CMP with a Medicare risk-sharing contract to notify enrolled beneficiaries and potential enrollees that the organization may legally terminate or refuse to renew the contract, and that beneficiaries' enrollments may be terminated if this should occur. The notice would be included in any promotional materials furnished to potential enrollees and in information provided to all enrollees at the time of enrollment and annually thereafter. (Identical provision included in Omnibus Budget Reconciliation Act of 1987).

(b) Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPs.—Increases the civil monetary penalty for failure to furnish medically necessary services to $25,000 for each failure. Provides for additional civil monetary penalties as follows:

(a) For each case in which an enrollee is charged a premium greater than permitted by law, $2,000 plus double the amount of the excess charge. The excess charge would be deducted from the penalty and returned to the enrollee.

(b) For each case in which the HMO/CMP expels or refuses to reenroll a beneficiary on the basis of health status, $15,000.

(c) For engaging in any practice which could reasonably be expected to result in denying or discouraging enrollment on the basis of health status, $100,000, plus $15,000 for each individual not enrolled as a result.

(d) For each case in which the HMO/CMP falsifies or misrepresents enrollment information furnished to the Secretary, any individual, or any other entity, or enrolls an individual without consent, or gives an individual a material inducement to enroll, $15,000. The penalty for each instance of false enrollment information furnished to the Secretary would be $100,000.

Provides that, in addition to or instead of imposing civil penalties, the Secretary may after notice to the organization suspend new enrollments or suspend payments to the HMO/CMP on behalf of new enrollees. Incorporates existing provisions on administration of civil monetary penalties.

Effective date.—(a) Applies to contracts entered into or renewed on or after the date of enactment.

(b) Becomes effective at the end of the 14 day period beginning on the date of enactment and does not apply to administrative proceedings commenced before the end of such period.

Conference agreement

The conference agreement includes the Senate amendment, with modifications. Only provisions not already enacted in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) are included. Excess premium charges collected from enrolleees are to be refunded, and an organization may be subject to a $15,000 civil monetary penalty for each case in which it expels or refuses to reenroll a beneficiary on the basis of health status.

29. Repeal of Authority to Administer Proficiency Examinations (Section 17 of Senate amendment)

Present law

Section 1123 of the Social Security Act allows the use of a testing program to determine the proficiency of individuals who desire to become skilled medical technicians. In the conduct of such tests, no individual who otherwise meets the proficiency requirements for the health care specialty can be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements. Currently, persons who are judged proficient as a result of this test may avoid going through an accredited education program designed to train such personnel.

House bill

No provision.

Senate amendment

Repeals section 1123, effective October 1, 1987. Provides that the repeal would not affect the authority of the Secretary to conduct the program established under 1123 prior to October 1, 1987 or the qualification of individuals to perform their duties and responsibilities who were certified by reason of previously administered exams.

Effective date.—October 1, 1987.

Conference agreement

The conference agreement includes the Senate amendment. The conferees note that this authority had already expired on September 30, 1987.

Although the authority would have allowed the Secretary to develop proficiency examinations for a variety of health personnel, the only examinations ever administered were those for clinical laboratory personnel. The conferees have been advised that there may develop a shortage of such personnel in the future. If this occurrs, the conferees anticipate that consideration could be given to the appropriateness of authorizing a new examination for such personnel.

Effective date.—The conference agreement is effective October 1, 1987.

30. Study and Reports by the Office of Personnel Management on Offering Medicare Supplemental Plans to Federal Medicare Eligible Individuals, and Other Program Changes (Section 23 of Senate amendment)

Present law

(a) Study and Report.—Under the Federal Employees Health Benefits (FEHB) Program, Federal employees and annuitants and their dependents are offered health benefits coverage from a range of participating health benefit plans. Since the FEHB program offers no plans that only supplement Medicare's coverage, the benefits available under the plans in the FEHB program duplicate certain benefits under the Medicare program.

(b) Feasibility Study and Report.—Under Section 1882 of the Social Security Act, the Secretary is required to establish a procedure by which Medicare supplemental policies may be certified by the Secretary as meeting minimum standards and requirements if they meet or exceed certain model standards developed and adopted by the National Association of Insurance Commissioners and meet certain loss ratio requirements. If a State establishes a regulatory program that provides for the application of these same minimum standards and requirements to Medicare supplemental policies, then such policies issued in that State are deemed to have met the requirements under the Secretary's certification program.

Section 1882 defines Medicare supplemental policies as health insurance policies or other health benefits plans offered by a private entity to individuals covered by Medicare that supplement Medicare's coverage; policies or plans of one or more employers or labor organizations are not included in this definition.

House bill

No provision.

Senate amendment

(a) Study and Report.—Requires the Director of the Office of Personnel Management (OPM), no later than April 1, 1989, to conduct a study and submit a report to the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service regarding changes to the Federal Employees Health Benefits Program that may be required to incorporate plans designed specifically for Medicare eligible individuals and to improve the efficiency and effectiveness of the program.

Prohibits any Medicare supplemental plan recommended by the Director of OPM from duplicating benefits for which payment is made under Medicare. However, any such recommended plan (1) must cover expenses that are not payable by Medicare because of deductible and coinsurance amounts, and (2) may offer additional reimbursement where Medicare benefits are limited by fee schedule and for benefits not covered by Medicare which may be of value to Medicare eligible individuals.

(b) Feasibility Study and Report.—Requires the Director of the Office of Personnel Management, no later than April 1, 1989, to report to the appropriate committees of Congress whether it is feasible to adopt such standards as issued by the National Association of Insurance Commissioners as required by section 1882 of the Social Security Act for Medicare supplemental policies, when providing Medicare supplemental plans as a type of health benefits plan available under the Federal Employees Health Benefits Program.

Effective date.—The reports required by (a) and (b) are due no later than April 1, 1989.

Conference agreement

(a) *Study and Report.*—The conference agreement includes the Senate amendment.

(b) *Feasibility Study and Report.*—The conference agreement includes the Senate amendment.

Effective date.—The conference agreement is effective upon enactment.

31. Rate Reduction For Medicare Eligible Federal Employees (Section 22 of Senate amendment)

Present law

Under the Federal Employees Health Benefits (FEHB) Program, Federal employees and annuitants and their dependents are offered health benefits coverage from a range of participating health benefit plans. The premiums for such coverage are shared by the Federal Government and by the enrollees. Premium payments are deposited in the Employees Health Benefits Fund, from which benefit and administrative costs are paid.

Since the FEHB Program offers no plans that only supplement Medicare's coverage, the benefits available under the plans in the FEHB Program duplicate certain benefits under the Medicare program.

House bill

No provision.

Senate amendment

Requires the Office of Personnel Management, in consultation with carriers offering health benefits plans under the Federal Employees Health Benefits Program, to reduce the rates charged to Medicare eligible individuals participating in such health plans by the amount, prorated for each covered Medicare eligible individual, of the estimated cost of medical services and supplies which would have been payable by such plans if the catastrophic coverage benefits (those in sections 2(a), 3(a), 4, and 7(b) of this bill) had not been enacted.

Defines "Medicare eligible individual" as any annuitant, survivor of an annuitant, or former spouse of an annuitant (1) who is otherwise eligible for benefits under the Federal Employees Health Benefits Program, eligible for benefits under Part A of Medicare, and covered by Part B of Medicare, and (2) for whom benefits paid under Medicare are the primary source of health care benefits.

Provides that funds in the Employees Health Benefits Fund for the Federal Employees Health Benefits Program are available without fiscal year limitation for costs incurred by the Office of Personnel Management in making such rate reductions.

Effective date.—Provides that the reduced rates apply as of the effective date of the Medicare catastrophic coverage (items and services furnished after, and premiums for months beginning after, December 31, 1987).

Conference agreement

The conference agreement includes the Senate amendment, with technical amendments to insure that all catastrophic benefits would be included in determining the rate reduction.

Effective date.—The conference agreement is for health benefit plans beginning January 1, 1989.

32. Maintenance of Effort (Section 21 of Senate amendment)

Present law

Many older, disabled and retired workers participate in employer-sponsor group health insurance plans. There are no current Federal requirements that employer-sponsored health plans provide specific benefits to plan participants. For those employer group plans who are also covered by Medicare, employer plans are generally coordinated to supplement Medicare benefits or provide benefits that Medicare does not cover.

The proposed Medicare catastrophic legislation would result in duplicative coverage for many of those individuals receiving both Medicare and employer-sponsored health benefits.

House bill

No provision.

Senate amendment

(a) In General.—Provides that for the 1-year period beginning on the date of enactment of this act, if an employer provides health benefits to an employee or retired former employee (including a Federal employee or retired Federal employee) that are duplicative of new or improved health care benefits provided under this act or the amendments made by this act, the employer shall: (1) provide additional benefits to the employee or retired former employee that are at least equal in value to the duplicative benefits; or (2) refund to the employee or retired former employee an amount equal to the actuarial present value of the duplicative benefits.

(b) Regulations.—Requires the Secretary of Labor to issue such regulations as are necessary to carry out this provision.

Effective date.—Effective (1) during the 1-year period beginning on the date of enactment of this act; or (2) in the case of an employer who is providing duplicative health care benefits to employees or retired former employees under a collective bargaining agreement that is in effect on the date of enactment, until the expiration of the agreement.

Conference agreement

(a) *In General.*—The conference agreement includes the Senate amendment with the following amendments. Employers who, on enactment, provide health care benefits to employees or retired former employees that duplicate Part A benefits or Part B benefits (excluding covered outpatient drugs) as amended by this Act must provide to the employees or retired former employees an amount of additional benefits (which could include payment of the part B premium) or refunds, or both, that total at least the actuarial value of the duplicative Part A benefits or Part B benefits (excluding covered outpatient drugs). Duplicative benefits are determined net of any premiums paid employees or retired former employees that are attributable to the duplicative benefits.

(b) *Employers Covered.*—Employers (including public employers other than the Federal government) affected by this provision include those who provide duplicative Part A benefits whose actuarial value is at least 50 percent of the actuarial value (discounted to the value as of the date of enactment) of the average Part A benefits provided under this bill.

Also, employers (including public employers other than the Federal government) affected by this provision include those who provide duplicative Part B benefits whose actuarial value is at least 50 percent of the actuarial value (discounted to the value as of the date of the enactment) of the average Part B benefits that will be provided under this bill.

The conferees intend that employers contributing to a multiemployer plan would be required to continue their contributions under their collective bargaining agreements.

Employers may elect to compute the actuarial value of duplicative Part A or Part B benefits on the basis of: (1) national average actuarial values, or (2) the actuarial value (net of employee premiums) with respect to that employer. The Secretary of Health and Human Services must calculate and publish for four years beginning with 1989 for duplicative Part A benefits, and 1990 for duplicative Part B benefits, the national average actuarial value of the duplicative benefits for 1988 and the year involved, and the employer guidelines for computing the actuarial value of duplicative benefits for such years.

(c) *Effective Period.*—The conference agreement includes the Senate amendment, with a modification that the maintenance of effort requirements with respect to duplicative Part A benefits are effective during 1989, and the maintenance of effort requirements with respect to duplicative Part B benefits are effective during 1990. However, where there is a collective bargaining agreement in effect of the date of enactment, the maintenance of effort requirements are in effect until the later of 1989 for Part A benefits and 1990 for Part B benefits or the expiration of the agreement, determined without regard to any extensions after enactment.

(d) *Effective date.*—The conference agreement is effective on enactment.

33. Medicaid Buy-In of Premiums and Cost-Sharing for Indigent Medicare Beneficiaries (Section 301 of House bill; Sections 14 and 14B of Senate amendment)

Present law

Most States have entered into a "buy-in" agreement under which they pay the Medicare Part B premiums on behalf of their Medicaid beneficiaries who are also eligible for Medicare.

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) permits States to cover Medicare premiums, deductibles, and coinsurance for aged and disabled persons with incomes up to a State-established level, which may be up to 100 percent of the Federal poverty line. A State choosing this option is required to use the resource standards of the Supplemental Security Income (SSI) program; except that if it has a medically needy program using higher standards it may use those standards. States electing this option are required to offer Medicaid coverage "to some or all" newly pregnant women and children below the Federal poverty line.

House bill

(a) In General.—Makes mandatory the current option for States to pay Medicare premiums, deductibles and coinsurance for all elderly and disabled persons with incomes at or below 100 percent of the Federal poverty level, except that resources would be set at or below twice the SSI standard. The requirement that States cover some newly eligible pregnant women and children is retained. A State which is providing medical assistance under a section 1115(a) waiver instead of under Medicaid is required to meet the mandatory coverage requirement. The coverage requirement is optional with the commonwealths and territories, and they may use an income level below 100 percent of the Federal poverty line.

(b) Drug Provisions.—(See Item 10, "Coverage of Catastrophic Prescription Drugs Under Medicare").

(1) Requires State Medicaid programs to cover incurred drug charges below the Medicare deductible for Medicare beneficiaries with incomes below poverty. Alternatively, a State may

provide the same drug coverage (up to the deductible) as is offered to categorically needy Medicaid beneficiaries in the State.

(2) No provision.

Effective date.—(a) Applies to calendar quarters beginning on or after July 1, 1988 (without regard to whether or not final regulations have been promulgated) with respect to medical assistance for monthly Medicare premiums beginning July 1, 1988, and items and services furnished on or after that date. Delay is permitted where State legislation is required.

(b) Applies for calendar quarters beginning on or after January 1, 1989 (without regard to whether or not final regulations have been promulgated) with respect to medical assistance for monthly Part B premiums beginning January 1, 1989, and covered outpatient drugs dispensed on or after that date; delay is permitted where State legislation required.

Senate amendment

(a) In General.—Requires the Secretary, before the beginning of each fiscal year, to estimate the amount that would have been expended from State funds that fiscal year for Medicaid in the absence of the catastrophic protection offered under the bill and to notify each State of the amount. Each State is required to use such estimated savings for one or more of the following:

(1) Paying for Medicare cost-sharing charges (other than those for covered outpatient drugs) for persons below the poverty line, pursuant to the provisions of OBRA 86 (except that requirements pertaining to additional coverage of pregnant women and children would not apply);

(2) Increasing the monthly maintenance needs allowance for community spouses of institutionalized individuals; or

(3) Increasing opportunities for elderly persons to participate in adult day health and other community-based services, if the State both: (A) has elected to provide coverage for Medicare cost-sharing charges for persons with incomes up to 100 percent of poverty, and (B) provides a minimum monthly income allowance for community spouses up to $500 per month.

The amounts expended by the State under this provision are in addition to any amounts that would have otherwise been expended for such purposes.

(b) Drug Provisions.—(See Item 10, "Coverage Catastrophic Drugs Under Medicare".)

(1) Similar provision.

(2) Permits States to cover Medicare prescription drug cost-sharing charges for persons whose income is between 100 and 200 percent of poverty. For persons with incomes up to 150 percent of poverty, the deductible can be up to $150 and the cost sharing amount up to 10 percent of any coinsurance amounts otherwise paid by the State. For persons with incomes above 150 percent of poverty, the deductible can be up to $300 and the coinsurance up to 15 percent.

Effective date.—(a) Applies for 12 successive calendar quarters beginning January 1, 1988, except delay is permitted where State legislation is required. In case of delay, the provision is also effective for 12 successive calendar quarters.

(b) Applies to Medicaid payments for calendar quarters beginning on or after January 1, 1990 (without regard to whether final regulations have been issued) with respect to monthly Medicare premiums and items and services furnished on and after January 1, 1990.

Conference agreement

(a) *In General.*—The conference agreement follows the House provision with modifications. Except with respect to certain "209(b)" States, the buy-in requirement would be phased in as follows: effective January 1, 1989, States would have to buy-in the elderly and disabled with incomes at or below 85 percent of the Federal poverty income guidelines ($5,770 per year in 1988 for an individual); effective January 1, 1990, at or below 90 percent; effective January 1, 1991, at or below 95 percent; and effective January 1, 1992, at or below 100 percent. With respect to those five "209(b)" States that, as of January, 1987, used more restrictive income eligibility standards with respect to the elderly than those applicable under SSI, the buy-in requirement would be phased in as follows: effective January 1, 1989, these States would be required to offer buy-in coverage to individuals with income at or below 80 percent of the Federal poverty income guidelines; effective January 1, 1990, at or below 85 percent; effective January 1, 1991, at or below 90 percent; effective January 1, 1992, at or below 95 percent; and effective January 1, 1993, at or below 100 percent. The conferees understand that five "209(b)" States qualify for this extended phase-in schedule: Hawaii, Illinois, North Carolina, Ohio, and Utah, (See CRS Report 87-986 EPW, Appendix B-2).

The conferees note that the current option to offer buy-in coverage would remain in effect during the phase-in period. Thus, States which currently offer buy-in coverage to the elderly or disabled with income at or below 100 percent of the Federal poverty guidelines but above the mandatory phase-in schedule (i.e., Florida, New Jersey, Rhode Island, and the District of Columbia) could continue to receive Federal matching payments for such coverage. Similarly, States that, over the next three years, wish to offer buy-in coverage to individuals with incomes above the mandatory phase-in schedule (but no higher than 100 percent of poverty) may do so.

The conference agreement clarifies the standard in the House bill that States cover "some or all" pregnant women and infants. Under the agreement, States are required, effective July 1, 1989, to extend coverage to pregnant women and infants up to age 1 with incomes at or below 75 percent of the Federal poverty income guidelines ($9,690 in 1988 for a family of 3); effective July 1, 1990, the requirement applies to all pregnant women and infants with incomes at or below 100 percent of poverty. In the case of pregnant women, coverage would be limited to pregnancy-related services; in the case of infants, coverage would extend to all Medicaid benefits offered be the State to cash assistance recipients. Those States that, as of enactment, offered overage to pregnant women and infants with incomes at or below 100 percent of the poverty level (or some lower income threshold higher than 75 percent) would be required to continue this coverage. This maintennance of effort requirement would also apply to States that, as of enactment, had enacted authorizing or appropriations legislation to establish such coverage but had not yet actually implemented the coverage. As under current law, States that elected to offer Medicaid coverage to pregnant women and infants above the mandatory income thresholds up to 185 percent of the Federal poverty level would not be permitted to reduce their cash assistance payment levels to families with dependent children below the levels in effect as of July 1, 1987. Similarly, to assure that the resources for mandatory coverage of pregnant women and infants up to 100 percent of poverty are not diverted from the Aid to Families with Dependent Children (AFDC) program, all States are prohibited from reducing their cash assistance payment levels to families with dependent children below the levels in effect on May 1, 1988.

The conference agreement also provides that states which impose durational limits on Medicaid payments for inpatient hospital services (e.g., 12 days per year, 14 days per admission, 30 days per spell of illness, 35 days for a particular diagnosis under a prospective payment system) must establish exceptions to any such limit for medically necessary inpatient services received by an infant (up to age 1) in a hospital designated as a disproportionate share hospital under the State's Medicaid plan. Thus, so long as the infant remains Medicaid-eligible and is receiving medically necessary inpatient services in a disproportionate share hospital, the State would be obligated to reimburse the hospital for such services without regard to any durational limit that might otherwise apply. The agreement further provides that, if a State pays for inpatient hospital services on a prospective basis (per diem, per case, or otherwise), the State must provide for an outlier adjustment for disproportionate share hospitals for medically necessary inpatient services delivered on or after July 1, 1989, involving exceptionally high cost or exceptionally long lengths of stay for infants up to age 1. States would have the discretion to define length of stay and cost outliers, and to determine the amount of adjustment to be paid for outlier cases; however, reimbursement to disproportionate share hospitals for these exceptionally high costs or exceptionally long length of stay infants would have to be reasonable and adequate. States are required to submit a plan amendment setting forth their outlier policy by April 1, 1989; the Secretary is required to review and approve or disapprove such amendment within 90 days. If the Secretary disapproves the amendment, the State is required to submit immediately a complying amendment. This requirement applies to all States, including those with "prudent buyer" contracting waivers under section 1915(b)(4) of the Social Security Act.

(b) *Drug Provisions.*—

(1) The conference agreement follows the House provision with a modification providing for a phase-in schedule corresponding to the schedule applicable to the general buy-in requirement described in (a), above. Thus, as of January 1, 1991, when the Medicare prescription drug benefit takes effect, most States will be required to buy-in the elderly and disabled with incomes at or below 95 percent of the Federal poverty level; in the five "209(b)" States for which a longer phase-in schedule is

specified, the 90 percent threshold will apply. The managers note that, if the State elects the option of providing its Medicaid drug benefits in order to satisfy the Medicare prescription drug deductible, the "charges for covered outpatient drugs" are the billed charges for the drugs that Medicaid covers, even though the beneficiary has not actually incurred the charge or paid the difference between the State's payment (plus any coinsurance requirement) and the pharmacist's charge.

(2) The conference agreement does not include the Senate provision.

Effective date.—Applies to calendar quarters beginning on or after January 1, 1989 (without regard to whether or not final regulations have been promulgated) with respect to medical assistance for monthly Medicare premiums beginning on that date, and items and services furnished on or after that date. Delay is permitted where specified State legislation is required. The disproportionate share hospital payment provision is effective on enactment.

34. Determination of Medicaid Drug Savings; State Plan Requirement (Section 14A of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

Requires the Secretary before the beginning of each fiscal year (or portion thereof) to estimate and determine the amount that would have been spent in each State that fiscal year under Medicaid in the absence of the new outpatient drug coverage and intravenous drug coverage provisions, and to notify the State of the amount.

Requires each State plan to use any such savings for covering Medicare drug cost sharing charges for persons below the poverty line.

Effective date.—Applies with respect to any calendar quarter beginning on or after January 1, 1990.

Conference agreement

The conference agreement does not include the Senate provision.

35. Protection of Income and Resources of Couple for Maintenance of Community Spouse (Section 302 of House bill; Section 14C of Senate amendment)

Present law

(a) In General.—Eligibility of the aged and disabled for Medicaid is linked to actual or potential receipt of cash assistance under SSI. The SSI program employs certain criteria for the treatment of income and resources which are also used in States which cover all SSI recipients. ("209(b)" States which do not cover all SSI recipi-

ents, may employ more restrictive criteria, provided they are no more restrictive than those in effect in January 1972).

An institutionalized individual with a spouse in the community is permitted to keep an amount for the maintenance needs of his spouse; however this amount is set at welfare levels. As a result of Medicaid rules, both for determining eligibility and in the treatment of income after eligibility has been established, the spouse in the community may be left with income below the poverty level; this circumstance is referred to as spousal impoverishment.

(b) Rules for Treatment of Income.—Under SSI rules, if both spouses live together, their incomes and resources are considered available to each other whether or not they actually contributed to each other. Spouses are no longer considered to be living together if one is institutionalized for longer than one month in a facility certified to receive Medicaid payments. Only the income of the institutionalized spouse is considered for purposes of determining eligibility. In most states the "name on the instrument" rule applies in attributing income; i.e., income is considered to belong to the spouse whose name is on the check or other instrument conveying the funds. (In the case of Social Security checks, the amount attributable to each spouse is the individual's share of the couple's benefit.) A Federal Appeals Court has ruled that in California and Washington, community property principles, and not the "name on the instrument" rule, apply.

(c) Rules for Treatment of Resources.—Resources must be considered mutually available for 6 months following institutionalization if both spouses are SSI eligible and for 1 month if only one spouse is SSI eligible. Countable resources above specified amounts (including a minimum of $1,900 in liquid resources for an individual and $2,850 for a couple) must be applied to the costs of care. Excluded from the calculation is the couple's home and $2,000 in equity value of household goods or personal effects. If resources are held solely by the institutionalized spouse, they are attributed to him for eligibility purposes. If they are held jointly by the institutionalized spouse and the noninstitutionalized spouse, they are considered to belong entirely to the institutionalized spouse. If they are held solely by the spouse remaining in the community, none is considered available to the institutionalized spouse.

(d) Protecting Income for Community Spouse.—After an institutionalized individual has established eligibility, his income, after deduction of specified amounts known as "disregards," is applied to the cost of care. The disregards are applied to the resident's income in the following order:

(1) A monthly personal needs allowance (which must be at least $25) ($30 as of July 1, 1988);

(2) A monthly maintenance needs allowance for an individual with a spouse at home which may not exceed: (A) the SSI standard for an individual residing in his own home, (B) the highest income standard for State optional supplementary payments, or (C) the medically needy standard for one person. (A State not covering all SSI recipients cannot use a level higher than the more restrictive income standard or the medically needy standard);

(3) An additional allowance for an individual with a family at home.

(4) Amounts for medical expenses not covered by a third party, subject to reasonable limits. (The Health Care Financing Administration (HCFA) has issued a regulation that, effective April 8, 1988, makes this disregard optional with the State.

(e) Notice and Hearing.—No provision.

(f) Court Ordered Support.—In certain instances State or local courts have issued orders against institutionalized spouses requiring them to make monthly payments to the community spouse. However, notwithstanding such an order, the Health Care Financing Administration (HCFA) has determined that the income of the institutionalized spouse is available to him for purposes of determining his contribution to the cost of care.

(g) Transfer of Assets.—The fair market value of any resources (not including the individual's home) disposed of within the preceding 24 months must be taken into account in determining SSI eligibility (to which Medicaid eligibility is linked). States are permitted, but not required, to impose such a restriction for Medicaid provided it is not more restrictive than that for SSI, with one exception. In cases where the uncompensated value of disposed resources exceeds $12,000, the State may provide for a period of ineligibility exceeding 24 months, provided the period bears a reasonable relationship to the uncompensated value. States may waive the delay in Medicaid eligibility in cases of undue hardship.

States are also allowed to deny Medicaid eligibility for 24 months to institutionalized individuals who, within 24 months prior to application for Medicaid, disposed of their homes for less than fair market value even though such disposal would not make them ineligible for the SSI program. The provision does not apply if the individual intended to dispose of the home at fair market value or if title was transferred to a spouse or minor or handicapped child.

(h) Conforming Amendment.—Some States covering the aged and disabled medically needy use less restrictive income or resource methodologies than are applied under the SSI program. HCFA has interpreted current law to require that States use SSI income and resource methodologies. A moratorium on this interpretation enacted in section 2373(c) of P.L. 98-369, and clarified by section 9 of P.L. 100-93, is currently in effect.

(i) Study of Means of Recovering Costs of Nursing Facility Services From Estates of Beneficiaries.—Under certain circumstances, States may recover amounts paid on behalf of deceased beneficiaries who were nursing home residents or who were 65 or over when Medicaid payments were made.

House bill

(a) In General.—

(1) Adds a new Section 1921 to the Social Security Act entitled "Treatment of Income and Resources For Certain Institutionalized Spouses". The provisions of this section supersede other provisions of title XIX, to the extent they are inconsistent, for purposes of determining eligibility of an institutionalized spouse. Comparable treatment is not required for other groups of eligibles.

(2) Specifies that, except as specifically provided, the section does not apply to the determination of what constitutes income or resources or the methodology and standards for determining and evaluating them.

(3) Permits an institutionalized spouse to elect to be governed instead by the rules in effect in March 1987 in his State, except that the institutionalized spouse may not opt out of the new rules regarding treatment of resources at the time of initial eligibility determination.

(4) Specifies that the new section applies to a State operating under a section 1115 waiver but not to the commonwealths and territories.

(b) Rules for Treatment of Income.—

(1) Specifies that in any month in which a spouse is institutionalized, no income of the community spouse is considered available to the institutionalized spouse.

(2) Specifies that, regardless of State laws relating to community property or division of marital property, the following income attribution rules apply for non-trust property unless otherwise specifically provided on the instrument. Income paid solely to one spouse or another is considered to belong to that respective spouse. If the income is paid in both names, half is considered available to each spouse. If the income is paid in the name of either or both spouses and another person, an equal share of the income is considered available to each individual. The same principles apply for trust property unless the trust specifically provides otherwise. For non-trust property with no instrument, half of the income is considered available to each spouse.

(3) An institutionalized spouse can rebut the non-trust property attribution rules by establishing that ownership interests are otherwise.

(4) No provision.

(c) Rules for Treatment of Resources.—

(1) Provides for the computation, as of the beginning of a continuous period of institutionalization, of the spousal share which is equal to one-half the value of all the resources held by the institutionalized spouse, the community spouse, or both. The couple's house and all household goods and personal effects are to be excluded from the calculation.

(2) Provides that the determination of countable resources is to be made regardless of State laws relating to community property or division of marital property, at the time of application for benefits. All resources held by either spouse are considered available to the institutionalized spouse except that the resources held in the name of the community spouse are not considered available unless they exceed a community spouse resource allowance (as of the application date) or if greater, the amount retained under court order.

(3) No provision.

(4) Provides that after an institutionalized spouse has established eligibility, no resources of the community spouse shall be considered available to the institutionalized spouse.

(5) Specifies that if the spousal share is less than $12,000 (indexed to the CPI beginning in 1989), the institutionalized spouse is allowed to transfer an amount sufficient to enable the community spouse to hold $12,000 in his or her own name. If the spousal share is greater than $48,000 (indexed by the CPI beginning for 1989), the amounts in excess of $48,000 would be attributed to the institutionalized spouse.

(d) Protecting Income for Community Spouse.—Specifies that the following disregards are to be applied to the institutionalized individual's income in the following order:

(1) A monthly personal needs allowance as specified under current law;

(2) A minimum monthly maintenance needs allowance for the community spouse. The allowance is the amount needed to bring the community spouse's monthly income up to a minimum level (not to exceed $1,500, indexed to the CPI beginning for 1989) which is the sum of:

(A) 150 percent of the Federal poverty guidelines for a family of two;

(B) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30 percent of Item A); and

(C) one-half of the amount by which the income of the institutionalized spouse exceeds the sum of items A and B;

(3) A family allowance for each family member (minor or dependent child, dependent parent or dependent sibling residing with the community spouse) equal to at least one-third of the amount by which 150 percent of the Federal poverty line for a family of two exceeds the family income of that family member.

(4) Amounts for incurred medical expenses not subject to payments by a legally liable third party.

(e) Notice and Hearing.—

(1) Requires States to notify the institutionalized spouse of the community spouse monthly income allowance, the family allowance, the method for computing the amount of the community spouse resource allowance, and of the spouse's right to a fair hearing with respect to the determination of the community spouse monthly income allowance.

(2) Specifies that if the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is inadequate to support the community spouse without financial duress, the amount is to be increased.

(f) Court Ordered Support.—

(1) Provides that if a court has entered an order against an institutionalized spouse for monthly income support for the community spouse, the community spouse monthly maintenance needs allowance must be at least as great as the court ordered amount.

(2) Provides that if a court has entered a support order against an institutionalized spouse requiring the spouse to transfer countable resources to the community spouse, such transfer will not be considered in violation of transfer of assets prohibitions.

(3) Provides that if a court has entered an order against an institutionalized spouse requiring the spouse to transfer resources, the community spouse resource allowance is the amount transferred up to the ceiling ($48,000 in 1988, indexed to the CPI in future years).

(g) Transfer of Assets.—

(1) Requires States to determine, at the time of application, whether an institutionalized individual has disposed, within the preceding 24 months, of resources for less than fair market value. If such a transfer has occurred, a period of ineligibility is established beginning with the month in which the resources were transferred. The number of months in such period equals the total uncompensated value at the time of transfer divided by the average cost of nursing home care to a private patient in the State or community.

(2) Specifies that the transfer prohibition does not apply if:

(A) the transfer was that of the applicant's home to his or her spouse, child under 21 or blind or disabled adult child;

(B) resources were transferred to the community spouse;

(C) a satisfactory showing is made that the individual intended to dispose of resources at fair market value or for other valuable consideration; or

(D) the State determines that denial of eligibility would work an undue hardship. States can only employ transfer of resources restrictions in accordance with these provisions.

(h) Conforming Amendment.—Provides that a State's methodology for determining eligibility for the medically needy may not be more restrictive than that under the appropriate cash assistance program. The methodology is considered to be no more restrictive if, in using the methodology, additional individuals may be eligible and no otherwise eligible individuals are made ineligible.

(i) Study of Means of Recovering Costs of Nursing Facility Services From Estates of Beneficiaries.—No provision.

Effective Date.—Applies to payments made for calendar quarters beginning on or after January 1, 1988, without regard to whether final regulations have been issued. Delay is permitted where State legislation required. The conforming amendment item (h) applies to medical assistance furnished on or after October 1, 1982.

Senate amendment

(a) In General.—Identical provision, except excludes item 3.

(b) Rules for Treatment of Income.—

(1) Identical provision.

(2) Similar provision except: (A) applies only to post-eligibility treatment of income; and (B) in the case of both trust and non-trust property where the income is paid in the name of either or both spouses and another person, the income is considered available to each spouse in proportion to the spouse's interest (or if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(3) Identical provision.

(4) Specifies that in the case of community property States that do not provide coverage for the medically needy, the amount of income considered available to each spouse, at the time of application for benefits, is equal to half of the combined income of the institutionalized and community spouse.

(c) Rules for Treatment of Resources.—

(1) Similar provision. Also excludes resources that are necessary to produce income that is available to the community spouse or the family allowance up to the limits established by this section (see (d) below).

Requires the State to provide an assessment and documentation of total joint resources at the request of either spouse, at the beginning of a continuous period of institutionalization. The assessment shall occur promptly on receipt of relevant documentation. A copy is to be provided to each spouse. A State may charge a reasonable fee for an assessment if it is not part of an application for Medicaid.

(2) Similar provision.

(3) Specifies that the institutionalized spouse is not considered ineligible by resources determined to be available where: (A) the institutionalized spouse has assigned to the State any rights to support from the community spouse; (B) the institutionalized spouse lacks the ability to excute an assignment due to physical or mental impairment but the State has a right to bring a support proceeding against a community spouse without such assignment; or (C) the State determines denial of eligibility could work an undue hardship.

(4) Identical provision.

(5) Similar provision, except: (A) a State, by law, practice, policy, or State plan (whether approved or not), may establish a higher amount than $12,000; and (B) specifies that a higher amount may be established by fair hearing or court order. Specifies that a transfer of resources to a community spouse must be made within 1 year after the date of the initial eligibility determination or such time as is necessary to obtain a court order (whichever is longer.)

(d) Protecting Income for Community Spouse.—Similar provision, except:

(1) The definition of personal needs allowance is tied to that specified under the bill.

(2) The minimum allowance for the community spouse may be increased by State law, policy, or State plan (whether approved or not):

(A) The minimum maintenance needs allowance is 122 percent of the poverty line;

(B) Similar provision.

(C) No provision.

(3) Similar provision, except family allowance linked to 122 percent of Federal poverty line.

(4) Similar provision.

(e) Notice and Hearing.—

(1) Similar provision, execpt requires specific notice to both spouses at the time of eligibility determination or to either spouse upon request. Also requires notification of the spouse's

right to a fair hearing respecting ownership or availability of income or resources, and respecting the community spouse monthly income or resource allowance.

(2) Specifies that if either spouse establishes that either the minimum monthly maintenance needs allowance or the community spouse resource allowance (in the relation to the amount of income generated by such allowance) is not adequate to support the community spouse without financial duress, the amount of either allowance is to be increased.

(f) Court Ordered Support.—

(1) Similar provision.

(2) Similar provision.

(3) Similar provision, except ceiling does not apply.

(g) Transfer of Assets.—Similar provision except that the State review covers the disposal of assets within the 26 months prior to application.

(2) Similar provision, except:

(A) specifies transfer prohibition does not apply (i) in the case of a sibling who has an equity interest in the home and was residing in the home for at least a year prior to the individual's admission to a nursing home, or

(ii) in the case of a son or daughter who was residing in the home for at least two years prior to the admission and was providing care which permitted the individual to reside at home.

(B) also permits transfer to the individual's child who is permanently or totally disabled.

(C) also permits a showing that resources were transferred exclusively for a purpose other than to qualify for medical assistance.

(D) Identical provisions.

(h) Conforming Amendment.—Identical provision.

(i) Study of Means of Recovering Costs of Nursing Facility Services From Estates of Beneficiaries.—Requires the Secretary to study the means for recovering the amounts from the estates of deceased beneficiaries (or the estates of spouses of deceased beneficiaries) to pay for SNF or ICF services furnished them under Medicaid. The Secretary is required to report to Congress, not later than December 31, 1988, on such means, and to include appropriate recommendations for changes.

Effective date.—Applies to payments made for calendar quarters beginning on or after January 1, 1988, without regard to whether final regulations have been issued. Delay is permitted where State legislation required. Provisions relating to treatment of resources, apply only to institutionalized individuals who begin continuous periods of institutionalization on or after January 1, 1988. Transfer of assets provisions, item (g) apply only to transfer of resources made on or after January 1, 1988.

Conference agreement.

(a) *In General.*—The conference agreement follows the Senate amendment.

(b) *Rules for Treatment of Income.*—The conference agreement follows the Senate amendment with a modification deleting the provision relating to community property States that do not offer coverage to the medically needy (item (4) of the Senate amendment).

(c) *Rules for Treatment of Resources.*—The conference agreement follows the Senate amendment with the following modifications. If the spousal share the couple's total resources is greater than $60,000 (indexed by CPI beginning in 1990), amounts in excess of $60,000 would be attributed to the institutionalized spouse. A level higher than $60,000 could be established by fair hearing or court order. The State, by amending its State plan, could raise the $12,000 minimum resource allowance for the community spouse to any level up to the $60,000 (subject to indexing) statutory maximum.

The agreement does not exclude from countable resources those assets necessary to produce income available to the community spouse or the family allowance. Instead, the agreement provides that either the institutionalized or the community spouse may request a fair hearing as to whether the community spouse resource allowance is adequate to generate sufficient income to raise the community spouse's income to the minimum monthly maintenance needs allowance. The State must grant such a hearing within 30 days of request. If the State, after such a hearing, determines that the community spouse resource allowance is inadequate, the State must allow the community spouse to retain an adequate amount of resources to provide the minimum monthly maintenance needs allowance (taking into account any other income attributable to the community spouse), notwithstanding the amount of the State-established resource allowance. If either spousel requests an assessment or resources at the time of institutionalization, the State must, in providing the assessment give notice to the requesting spouse of the right to a fair hearing with respect to the adequacy of the community spouse's resource allowance. The agreement also requires that nursing facilities inform newly-admitted residents of their right to request an assessment from the State agency.

The conference agreement specifies that a transfer of resources to a community spouse must be made as soon as practicable after the date of initial eligibility determination, with allowance for the time necessary to obtain a court order, where necessary. In determining what constitutes a "transfer" for this purpose, the conferees intend that State law govern. In addition, the agreement provides that the State of Missouri must not count as a resource the home (of any value) of an aged, blind, or disabled individual who applies for Medicaid on or after October 1, 1989. This requirement would apply only to the home; the State could, but would not be requird to, exclude the land that appertains to the house, as would be the case under SSI.

(d) *Protecting Income for Community Spouse.*—The conference agreement follows the Senate amendment with the following modifications. As under current law, the proposal needs allowance is $30, whether the resident is eligible for Medicaid on a categorically needy, optional categorically needy, or medically needy basis. The minimum monthly maintenance needs allowance is effective September 30, 1989, set at 122 percent of the monthly Federal poverty income guidelines for a 2-person household (which is 1988 would be $786). Effective July 1, 1991, the minimum allowance would be raised to 133 percent; effective July 1, 1992, to 150 percent. This schedule of percentage would also apply to the calculation of the family allowance. The community spouse monthly maintenance needs allowance may not exceed $1500, except where a higher level is determined to be necessary through a fair hearing or by a court order.

With respect to the deduction for incurred medical expenses, the conference agreement requires that, with respect to any Medicaid-eligible individual in an institution (regardless of whether the individual has a spouse in the community), States must take into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles, or coinsurance, and, subject to reasonable limits a State may establish, necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan. The conferees note that, until recently, HCFA regulations required that Medicaid-eligible nursing home residents be allowed to deduct uncovered medical costs from their income before contributing toward the cost of nursing home care. However, a recent HCFA regulation, 53 *Fed. Reg.* 3586 (Feb. 8, 1988), altered this rule to allow States to limit this deduction substantially, or to eliminate it altogether. The conference agreement is intended to reinstate the previous rule, retroactive to the effective date of the recent change (April 8, 1988). As under the previous regulation, States will have the ability to place "reasonable limits" on a resident's expenditures for medical or remedial care. The conferees wish to emphasize that these limits must ensure that nursing home residents are able to use their own funds to purchase necessary medical or remedial care not covered by the State Medicaid program, while minimizing opportunities for providers to take financial advantage of either the program or the residents. For example, it would be reasonable for a State to provide that only uncovered services prescribed by a physician may be deducted. It would also be reasonable for States to impose specific dollar limits for specific services or items, provided that these limits reflect annual increases in the cost of medical care services and supplies. However, it would not be reasonable for States to set an overall dollar limit, such as $50 per month, for all noncovered services. Similarly, it would not be reasonable for States to impose a limit on the number of medically necessary services or items that an individual could deduct in any month. In providing these examples of "reasonable limits" for deductions of uncovered medical expenses incurred by nursing home residents, the conferees do not intend any approval of camparable limitations in the "spenddown" process for medically needy programs.

(e) *Notice and Hearing.*—The conference agreement follows the Senate amendment with the following modification. If either the community or institutionalized spouses establishes in a fair hearing that, due to exceptional circumstances resulting in significant financial duress, the community spouse needs income above the minimum monthly maintenance needs allowance, the State is required to increase the allowance to provide this amount, notwithstanding the $1500 statutory ceiling. Exceptional circumstances resulting in significant financial duress would include, but not be limited to, the financial burden of caring for a disabled child, sibling, or other immediate relative. If either spouse establishes in a fair hearing that the community spouse resource allowance (in relation to the income generated by such allowance) is inadequate to raise the income of the community spouse to the level of the minimum monthly maintenance needs allowance (taking into account any other income attributed to the community spouse), the State must provide for a resource allowance adequate in amount to generate that level of income for the community spouse.

(f) *Court-ordered Support.*—The conferences agreement follows the Senate amendment.

(g) *Transfer of Assets.*—The conference agreement follows the Senate amendment, with a modification. The transfer of assets prohibitions apply only with respect to individuals institutionalized in a medical institution or nursing facility. The term "medical institution" has the same meaning as under current regulations, 42 C.F.R. section 435.1009; the term "nursing facility" includes a skilled nursing facility or intermediate care facility (other than an ICF for the mentally retarded), until October 1, 1990, when these categories will be replaced by "nursing facility." States are required to determine whether these individuals made any prohibited resource transfers within 30 months prior to application for benefits. This requirement is effective with respect to applications for Medicaid eligibility occurring on or after July 1, 1988 and applies only with respect to resources transferred on or after July 1, 1988. Thus, in those States which do not have transfer or assets prohibitions in place prior to July 1, 1988, the State can look back only to transfers occurring on or after July 1, 1988. In those States that, prior to July 1, 1988, have exercised their option to penalize transfers of assets for less than fair market value, the State may continue to apply its pre-July 1 transfer policies and penalties with respect to resources transferred prior to July 1, 1988, even in cases where application for Medicaid benefits is made after on or after that date. However, with respect to resource transfers occurring on or after July 1, 1988, the rules set forth in the conference agreement regarding computation of the period of ineligibility and exceptions to the transfer prohibition will apply in all States, including the "209(b)" States which have elected the option to use more restrictive eligibility standards with respect to their aged, blind, and disabled beneficiaries than apply under SSI.

The conference agreement also repeals the provision in present SSI law which requires that the uncompensated value of resources transferred at less than fair market value within the preceding 24 months be counted toward the SSI resource limit. However, under the conference agreement, a transfer of resources at less than fair value by an SSI applicant or recipient will be considered in determining an individual's eligibility for Medicaid if and when the individual enters a medical institution or nursing facility. Such transfers may include, for example, the SSI applicant's or recipient's home even though at the time of the transfer the home was not a countable SSI resource. Therefore, the conference agreement will require that the Secretary inform SSI applicants in writing, at the time of application, and SSI recipients, at the time of redetermination of eligibility, of the provisions of Medicaid law with respect to transfer of assets. The Secretary will be required to request from the individual information about transfers and, at the time of such request, to inform the individual that such information may be shared with the State Medicaid agency. The Secretary will also be required to make this information available to a State Medicaid agency, upon request; the State may, at its option, use this information to determine whether and to what extent there will be a period of ineligibility for Medicaid because an individual transferred resources at less than fair market value.

(h) *Conforming Amendment.*—The conference agreement follows the House bill, which applies to States which cover the medically needy, with a modification extending its application to States which offer coverage to optional categorically needy individuals and to "209(b)" States as well. Under the moratorium imposed by section 2373(c) of P.L. 98-369, as clarified by section 9 of P.L. 100-93, States have flexibility to establish income and resource methodologies under medically needy programs, optional categorically needy programs, and under the "209(b)" option that are less restrictive, i.e. more generous, than those applied in the corresponding cash assistance programs. The conference agreement codifies this flexibility, retroactive to October 1, 1982.

(i) *Study of Means of Recovering Costs of Nursing Facility Services from Estates of Beneficiaries.*—The conference agreement includes a technical amendment reflecting the Senate amendment, the text of which had been agreed to in, but was inadvertently ommitted from, the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203. The conference agreement includes additional OBRA '87 technical corrections and other miscellaneous provisions.

With respect to section 4112 of OBRA '87, relating to payment adjustments for disproportionate share hospitals, the conference agreement makes a number of technical corrections regarding the 3-year phase-in and other matters. It clarifies that the special rule in subsection 4112(e) applies only to New York, and adds a special rule providing that, for a 3-year period, Texas may use its own definition of disproportionate share hospital and its own payment adjustment rules so long as the aggregate amount payment adjustments to disproportionate share hospitals is not less than the amount that would be required by section 4112. During this 3-year period, in meeting the requirement that at least two obstetricians with staff privileges agree to provide obstetric services to Medicaid patients, a hospital in an urban area in Texas seeking disproportionate share status could substitute family practitioners, internists, or any other qualified physician with staff privileges.

The conference agreement clarifies that Federal Medicaid matching funds are available for the cost of health services, covered under a State's Medicaid plan, that are furnished to a handicapped child or a handicapped infant or toddler, even though such services are included in the child's individualized education program or individualized family service plan. Under the Education for All Handicapped Childeren Act of 1975, P.L. 94-142, children with handicaps are entitled to a free and appropriate public education in conformity with an individualized education program (IEP) which describes the educational and "related services" necessary to meet the child's unique needs. While the State education agencies are financially responsible for educational services, in the case of Medicaid-eligible handicapped child, State Medicaid agencies remain responsible for the "related services" indentified in the child's IEP if they are covered under the State's Medicaid plan, such as speech pathology and audiology, psychological services, physical and occupational therapy, and medical counseling and services for diagnostic and evaluation purposes.

The conference agreement defines an institution for mental diseases (IMD) as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. This would clarify that Federal Medicaid matching funds would be available for services such as personal care and case management that are furnished through or by group homes or other small facilities serving the mentally ill, if those services are covered by the State under its Medicaid plan. The 16-bed limitation parallels current rules under the SSI program.

The conferees wish to clarify the requirements in sections 4201 and 4211 of P.L. 100-203 that nursing facilities with more than 120 beds must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualification) employed full-time to provide or assure the provision of social services. Facilities could meet this requirement by employing either a person with a dregree in social work or with similar professional qualifications, such as a degree in a related field and previous supervised experience in meeting individual psycho-social needs. It is the intent of the conferees that the Secretary ensure that requirements regarding consultation and supervision of social work services be at least as stringent as those in effect prior to enactment of these changes.

The conferees also wish to clarify that it was the intent of sections 4201 and 4211 of P.L. 100-203 that the Secretary ensure that the requirements for dietary services be at least as stringent as those in effect prior to enactment of P.L. 100-203.

36. Technical Amendment Relating to Home and Community-Based Services (Section 19 of Senate amendment)

Present law

Comparable provision included in section 4418(a) of Public Law 100-203.

37. Technical Amendments Relating to New Jersey Respite Care Pilot Project (Section 20 of Senate amendment)

Present law

Comparable provision included in section 4418(o) of Public Law 100-203.

38. Treatment of Garden State Health Plan (Section 25 of Senate amendment)

Present law

Comparable provision included in section 4113 of Public Law 100-203.

39. Technical Amendments Relating to the Omnibus Budget Reconciliation Act of 1987

Conference agreement

PART A AND AMENDMENTS AFFECTING BOTH PARTS A AND B

The conference agreement includes a number of technical and conforming amendments to the Medicare Part A and Parts A and B provisions of OBRA-87. These include:

(1) The prohibition on the issuance by the Secretary of any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures of more than $50 million is extended to October 15, 1989;

(2) Clarification that the regional floor on hospital payment applies on a census region basis, not a wage area basis;

(3) Clarification that outlying counties of metropolitan areas can only be designated as urban if they meet the commuting rules and all other applicable standards for designation as part of an urban area;

(4) In the case of hospitals with more than 49 beds using swing beds, authorization is provided to continue payment for patients in the hospital receiving skilled mursing care when the hospital reaches its limit for swing bed care;

(5) Clarification that the hospital cost report is to be permanent;

(6) Revisions to the uniform hospital reporting demonstration program to (i) delete date elements on which it is not feasible to collect information at this time; (ii) allow additional time for the collection of data and the preparation of a report; and, (iii) extend the period of time during which funds may be expended for the demonstration;

(7) Amendments to conform anti-fraud and abuse provisions of OBRA '87 to existing statutory provisions;

(8) Extension of the date for submission of a report on hospital quality assurance required by OBRA '86 to January 1, 1990.

(9) Clarification that the rule regarding payment for hospital services by pre-paid plans under section 1876 applies to contracts established under pre-TEFRA demonstration authorities;

(10) Clarification that the hospital payment rule applies only in the case of a pre-paid which does not have a contract with the hospital or the skilled nursing facility seeking payment for its services. Most often, the rule would apply in the case of out-of-plan services or when contract negotiations have not been successful. The hospital or the skilled nursing facility are free to establish any level or type of payment they wish through negotiations pursuant to a contract;

(11) Clarification of the application of the 50/50 rule to H.I.P./Network.

PART B AND PROS

The conference agreement includes a number of technical and conforming amendments to the Medicare Part B and PRO provisions of OBRA-87. These include:

(1) Consolidation of definitions relating to physician payment in new Section 1842(i);

(2) Amendments clarifying that there is only one prevailing charge for payment of physicians' services calculated on the basis of customary charges of participating and non-participating physicians. The differential between participating and non-participating physicians continues without change;

(3) Clarifying that reductions in payment for cataract surgery and requirements relating to the use of an assistant at-surgery for cataract surgery also apply to insertion of an interocular lens subsequent to cataract removal;

(4) Conforming amendments regarding maximum allowable actual charge limits for reductions in payment for concurrent anesthesia services;

(5) Clarifying amendment to the purchase service provision, including an amendment to allow for billing for such services on an unassigned basis;

(6) Amendments clarifying that the scholarship loan default offset provision applies to non-physician defaulters and to physician and non-physician defaulters under the Health Education Assistance Loan program and the Physician Shortage Area Scholarship program;

(7) An amendment clarifying that the 1975 prevailing charge floor continues but is phased-out as it is no longer needed;

(8) Corrections and clarifying amendments to the durable medical equipment fee schedule;

(9) Clarifying penalties for improper billing of interocular lenses included in payment to ASCs;

(10) Consolidating amendments incorporating OBRA-87 policies regarding clinical labs into the Social Security Act and clarifying amendments related to the effective date for the elimination of the 2% differential for hospital laboratories;

(11) Clarifying amendments for new Section 1846;

(12) Clarification of provisions relating to payment of hospital outpatient departments for radiology services;

(13) Clarifying amendments that the standard coinsurance applies to services of nurse midwives and clinical psychologists and conforming amendments applying the same penalties for improper unassigned billings to these services as apply to the services of certified registered nurse anesthetists and physician assistants;

(14) Clarifying amendments to the provision requiring coordination of claims with Medigap insurers and an amendment delaying the effectiveness of this provision for Medigap policies sold in states which did not enact necessary changes prior to July 1, 1988.

NURSING HOME REFORM

The conference agreement includes a number of technical and correcting amendments to the Medicare and Medicaid Nursing Home Reform provisions of OBRA 87. These include amendments revising effective date and other requirements. The effective dates for certain Medicare requirements are changed from the first date noted to the second date noted as follows:

(1) requirement that skilled nursing facilities conduct resident assessments: from October 1, 1990 to January 1, 1991;

(2) required training of nurse aides used by facilities: from October 1, 1989 (or January 1, 1990, in the case of an individual used as a nurse aid before July 1, 1989) to January 1, 1990;

(3) requirement for States to specify approved nurse aide training and competency evaluation programs: from March 1, 1989 to January 1, 1989;

(4) requirement for States to review and reapprove nurse aide training and competency evaluation: from March 1, 1990 to January 1, 1990;

(5) requirement for States to establish nurse aide registries: from March 1, 1989 to January 1, 1989;

(6) requirement for States to provide for an appeals process for transfers: from October 1, 1990 to October 1, 1989;

(7) requirement for States to specify the resident assessment instrument: from July 1, 1989 to July 1, 1990;

(8) requirement for the Secretary to establish guidelines for States appeals process for transfers: from October 1, 1989 to October 1, 1988;

(9) requirement for the Secretary to specify a minimum data set of core elements and common definitions for resident assessments: from July 1, 1989 to January 1, 1989;

(10) requirement for the Secretary to designate one or more resident assessment instruments: from October 1, 1990 to April 1, 1990;

(11) requirement that a facility permit immediate access to any resident by any representative of the Secretary or State, by an ombudsman, or by the resident's individual physician: effective on the date of enactment;

(12) requirement for the Secretary to develop, test, and validate standard and extended survey protocols: from October 1, 1990 to January 1, 1990.

Certain Medicaid effective dates have also been revised:

(1) requirement for States to specify approved nurse aide training and competency evaluation programs: from September 1, 1988 to January 1, 1989;

(2) requirement for States to review and reapprove nurse aide training programs: from September 1, 1990 to January 1, 1990;

(3) agreement between State and Secretary for disposition of residents who require active treatment: from October 1, 1988 to April 1, 1989;

(4) requirement for the Secretary to establish requirements for the approval of nurse aide training and competency evaluation programs: from July 1, 1988 to September 1, 1988;

(5) requirement that a facility permit immediate access to any resident by any representative of the Secretary or State, by an ombudsman, or by the resident's individual physician: effective on the date of enactment.

These amendments also clarify that nursing facilities are required to manage the personal funds of residents if requested to do so by the resident. The amendments also require States to make available to the public information in nurse aide registries.

With regard to requirements for social workers included in the OBRA 87 amendments, the conferees intend that the Secretary ensure that requirements regarding consultation and supervision of social work services be at least as stringent as those in effect prior to enactment of the OBRA changes.

RURAL HEALTH

Clarifies that the set aside for demonstrations applies to both research and demonstrations but only to funds appropriated to and expended by the Health Care Financing Administration. Conforms statutory language to intent of conferees that there be equal ten percent set-asides for rural and for inner city research and demonstrations.

From the Committee on Ways and Means, for consideration of titles I, II, and IV of the House bill, and the entire Senate amendment (except for secs. 14, 14A, 14B, 14C, 19, 20, and 25), and modifications committed to conference:

DAN ROSTENKOWSKI,
PETE STARK,
BRIAN J. DONNELLY,
WILLIS D. GRADISON, Jr.

From the Committee on Energy and Commerce, for consideration of titles II, III, and IV of the House bill, and the Senate amendment (except for secs. 2, 3, 12, and 18(a)) and for sec. 6 of the Senate amendment insofar as consideration of such section entails changes in eligibility requirements to participate in part B of the Medicare program, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
RON WYDEN,
EDWARD R. MADIGAN
(except for sec. 204 of the House bill and sec. 7 of the Senate amendment),

For consideration of sec. 204 of the House bill and sec. 7 of the Senate amendment:

MICHAEL BILIRAKIS,

From the Committee on Education and Labor, for consideration of sec. 21 of the Senate amendment, and modifications committed to conference:

GUS HAWKINS,
WILLIAM CLAY,
JAMES JEFFORDS,
Managers on the part of the House.

LLOYD BENTSEN,
MAX BAUCUS,
BILL BRADLEY,
GEORGE MITCHELL,
DAVID PRYOR,
JOHN H. CHAFEE,
JOHN HEINZ,
DAVID DURENBERGER,
Managers on the part of the Senate.

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